Case Summary:

Inquest touching upon the death of Mr Andrew Goldstraw

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FACTS

Mr Andrew Goldstraw was a 43 year old man with a significant history of alcohol dependency, substance abuse, depression, deliberate self-harm and attempts to take his own life. In or around 2015, Mr Goldstraw started a relationship with Ms Stacey Coleman. At times when Mr Goldstraw had consumed excessive alcohol, the relationship became abusive. In October 2018, Mr Goldstraw assaulted Ms Coleman and attempted to stab her in the head. He was arrested, charged with GBH and remanded in custody at Her Majesty's Prison (HMP) Winchester on 23 October 2018. On the morning of 14 November 2018, Mr Goldstraw was found hanged in his prison cell having used bedsheets to create a ligature from the window frame. On post-mortem examination, toxic levels of Fluoxetine and therapeutic levels of Mirtazapine were found in his blood and urine. Further, the breakdown product of '5F-ADB' (a synthetic cannabinoid substance, more commonly referred to as 'Spice') was found in his urine.

The most relevant background can be summarised as follows:

- In 2014, Mr Goldstraw was diagnosed with depression with symptoms that had been present for a couple of years. This had been exacerbated by his children being taken into care. He attended A&E with suicidal ideation. He stated that the main trigger for his symptoms was a feeling of hopelessness following relationship problems / breakdown. He was referred to a psychiatrist.

- In 2015, he attempted to end his life by inhaling fumes from household chemicals mixed together in the bathroom whilst sealing the room with masking tape. He had a breakdown contributed to by his relationship finally breaking down, child protection issues, being charged with assault and having difficulty living on his own together with the recent death of both parents and estrangement from his family who had taken a restraining order out on him.

- In 2017, Mr Goldstraw tried to hang himself with a dressing gown cord following an argument with his partner. He had also taken an overdose of Mirtazapine. This was described as an

impulsive overdose with no planning involved. He was transferred to prison following an assault and was due to be released in July 2017. He did not have accommodation in place following his release because there was a restraining order in place preventing him returning to his partner's property. As a result, he stated that he was thinking about taking his own life after release. Upon release, he was able to return to his partner's address because the restraining order had been lifted. However, he was worried about the lack of support that was in place for the problems with his mental health. He was very concerned about how he would cope upon release and felt he needed mental health support. Mr Goldstraw was then remanded at HMP Winchester for another assault. On induction, he is noted to have said to mental health staff that he had: (a) no mental health history; and (b) no history of self harm or suicide attempts.

- In July 2018, Mr Goldstraw was admitted to A&E following an impulsive overdose of his partner's Tramadol following an argument where she had said she was going to leave him. It was noted that his risk is impulsive and will increase with alcohol misuse and with a change of circumstances such as his relationship ending.

- On 23 October 2018, Mr Goldstraw was remanded in custody at HMP Winchester. He underwent an initial screening and induction process at reception. Further, he was assessed by healthcare staff on various occasions (including mental health nurses and the substance misuse team). Following an initial period of detoxification on C-wing, he was transferred to B-wing on 11 November 2018.

- At or around 21.00 on 13 November 2018, Mr Goldstraw was seen alive in his cell by a prison officer as part of a roll check of inmates. A further roll check was allegedly undertaken at or around 06.00 on 14 November 2018, which indicated that a full complement of inmates were alive and well in their cells. However, at or around 07.15, Mr Goldstraw was found hanged in his cell. It was subsequently admitted that the roll check carried out by the prison officer at 06.00 was never in fact completed despite her signing to confirm that she had completed it.

HM Deputy Coroner (HMC) Simon Burge held a two-week Article 2 inquest with a jury into Mr Goldstraw's death at Winchester Coroner's Court. HMC gave Interested Person status to: (a) Ms Coleman; (b) HMP Winchester; and (c) Central and North West London NHS Foundation Trust (the "Trust" responsible for the provision of healthcare at the prison).

ISSUES

The key issues explored at the inquest were:

- **Time of death**: The precise time of Mr Goldstraw's death was unknown. He was last seen alive in his cell during the roll check at 21.00 on 13 November 2018. He was found at or around 07.15 on 14 November 2018 by officers who described his body as cold to touch, pale and stiff. The Pathologist to the inquest was not prepared to give an exact time of death, but was able to say that if rigor mortis was present when he was found, then Mr Goldstraw had likely been dead for a number of hours.

- **The failure to carry out a roll check at 06.00**: The prison officer responsible was dismissed for gross misconduct following disciplinary proceedings. The question of whether this failure had caused or contributed to Mr Goldstraw's death ultimately fell away given the post-mortem evidence that he was likely to have been already dead at 06.00.

- **Risk of deliberate self-harm / suicide**:

    - This was the most significant issue explored at the inquest. HMC called a number of witnesses from the prison service and the Trust to give evidence about the assessment and management of Mr Goldstraw's risk of deliberate self-harm and suicide whilst at HMP Winchester in October / November 2018.

    - The key tool used by the prison in this regard is the "Assessment, Care in Custody and Teamwork" (ACCT) procedure. Prison and healthcare staff are encouraged to open an ACCT even if there is the slightest concern about an inmate's risk of self harm / suicide. Once an ACCT is opened, the inmate receives a structured assessment of their risk and a case management plan is put in place to help them through a time of crisis. The ACCT procedure allows staff to carry out periods of observation, have greater communication with the inmate and ascertain a deeper level of understanding of their risk and how best to manage it. In the absence of opening an ACCT, there was no mechanism for adequately monitoring, discussing or understanding the level of risk an inmate posed to themselves during their time in prison.

    - Prison officers that assessed Mr Goldstraw were aware of the relevant risk factors and triggers contained with PSI 64/2011. These include (but are not limited to): a previous history of self-harm and suicide, breakdown in personal and family relationships, alcohol and substance abuse, the nature of offence a person is charged with (specifically domestic violence), impending court dates, the presentation of an inmate and what is said during assessments. However, officers deferred to the more qualified mental health

nurses to conduct a detailed assessment of Mr Goldstraw's risk. Despite that, during the exploration of their evidence, it became clear that Mr Goldstraw had divulged relevant information during his interactions with officers that was not passed onto healthcare staff. For example, he had requested help with his mental health and with managing his anger and impulsive behaviour. However, officers did not have access to his medical history and were not aware of his previous attempts to take his own life. Therefore, they were only working with fragments of Mr Goldstraw's overall story which they deemed insufficient to start the ACCT procedure.

- When Mr Goldstraw was assessed by various healthcare staff (including mental health nurses and members of the substance misuse team) they accepted that they had access to his medical history. This was stored on the Trust's record management database ("SystmOne"). This included Mr Goldstraw's significant history of deliberate self-harm and attempts on his own life. However, not one of the healthcare staff that assessed Mr Goldstraw were aware of his history during their assessment. Instead, they had focussed solely on his presentation and what he told them during their assessment. Mr Goldstraw had told them he was not feeling depressed or suicidal and had no plans to self-harm or take his own life. On that basis, they assessed him as presenting no risk of self-harm / suicide. In evidence, they accepted that: (a) they had failed to take account of Mr Goldstraw's significant previous history of attempts on his own life of which they should have been aware; (b) they had failed to identify that Mr Goldstraw had provided false information to medical professionals previous in relation to his history of mental health, self-harm and suicide; (c) in addition to other risk factors that were not properly identified this resulted in an inadequate assessment of the risk Mr Goldstraw posed to himself; (d) had they been aware of Mr Goldstraw's history an ACCT should have been opened; and (e) this could have prevented Mr Goldstraw's death.

- **The provision of anti-depressant medication**: Despite Mr Goldstraw's significant history of substance abuse (including multiple overdoses of prescription medication), he was allowed to hold a week's worth of anti-depressants (Fluoxetine and Mirtazapine) in his own possession at one time. In evidence, staff on behalf of the Trust accepted that Mr Goldstraw should have been assessed as high risk of holding medication 'in-possession' and should have had it dispensed by the prison one pill at a time where staff could watch him take it. In addition, Mr Goldstraw had failed to pick up a prescription on 9 November 2018 which was considered a missed opportunity to identify possible non-compliance. Had this been investigated, it arguably could have identified that Mr Goldstraw was stockpiling his medication.

- **The use of synthetic cannabinoid substances (5F-ADB or 'Spice')**: The post-mortem evidence stated that Mr Goldstraw had traces of the breakdown product of 5F-ADB in his urine which indicated that he had taken Spice at some point before his death. The pathologist could not be clear when any such substance had been taken or how long before death. However, evidence from other inmates on B-wing was that Mr Goldstraw had been "off his head on Spice" the day before his death. The pathology and toxicology evidence showed that 5F-ADB and even its breakdown product can have potent psychological and psychotic effects on a person's state of mind that can last for days after it has left their system.

CONCLUSION

The jury returned a narrative conclusion. They accepted the following medical cause of death from the post-mortem report: *1(a) Ligature Suspension*. However, they added the following to (2): *Adverse psychological state due to combination of drugs and medication taken*. They stated as follows:

We, the jury, conclude that Andrew Goldstraw did and intended to take his own life. We base this on the following evidence: a significantly high number of triggers relating to his situation at the time, his history of attempts of suicide as well as the suicide letters found at the scene. It is more likely than not that he was going to take his own life at that date due to the significant anniversary of the date.

Mr Goldstraw was failed by multiple bodies in their duty of care and all they could have done to keep him alive. This included multiple failures of training and a lack of verification, a lack of cross-services communication (both verbal and systematic) and a lack of proactive background checks. An ACCT should have been opened, *the absence of which more than minimally contributed to Mr Goldstraw's death.* It would have resulted in awareness of his risk factors and would have resulted in cross-service communication.

He should not have been allowed to be in possession of his medication. It is more likely than not that it would have affected his psychological state. He had taken Spice. The evidence from the pathology report, as well as statements from fellow inmates, supports this. We agree that medication, in combination with Spice, would have had a more than minimal contribution to his death. The toxic levels of Fluoxetine and the adverse psychological effects of Spice will have had a more than minimal effect on his psychological state of mind and were a more than minimal contributing factor in the medical cause of death.

PREVENTION OF FUTURE DEATHS

A number of steps have now been taken in an effort to improve the assessment and management of an inmate's risk of deliberate self-harm / suicide. These include: a new risk assessment template, weekly multi-agency safety intervention meetings, the introduction of a scheme whereby all prisoners are now assigned a key worker and a joint bulletin to staff stressing the importance of sharing information.

However, following the conclusion of the inquest, HMC agreed to write a Prevention of Future Deaths report to address a number of ongoing concerns relating to: (a) the adequacy of the Trust's computer system (SystmOne); and (b) the training of healthcare staff assessing an inmate's risk of self-harm / suicide.

In particular, HMC stated as follows:

SystmOne makes it difficult for a doctor or mental health nurse to ascertain the key information needed to undertake a risk assessment and to decide whether or not to open an ACCT. Too much reliance is placed on the individual prisoner presentation and how he answers a series of pre-set questions.

At best, SystmOne makes it difficult for a mental health nurse to ascertain the relevant information and at worst it actively misleads them. For example, a search can be made of the "Journal" section but this would rely on the exact words being searched (such as "suicide" or "deliberate self-harm") and it would then be necessary to go through the various entries (in Mr Goldstraw's case spread over 111 pages) using the "Key Word Search" function. Further, the functions that would (on the face of it) serve to assist in this situation (such as the "Summary" page or "Active Problems" section) were not populated with the information relevant to an accurate assessment. It was conceded by the legal representatives acting on behalf of the Trust that the "Summary" section is "very limited in its contents" and is not routinely used by healthcare staff within the prison in order to gain an insight into a prisoner's past medical history.

The "Active Problems" section of SystmOne is subdivided in to a number of distinct areas and it appears to be wholly inadequate in terms of identifying key areas of concern such as the risk of suicide or deliberate self-harm. The only information contained in the "Active Problems" section of SystmOne in Mr Goldstraw's case was four years out of date. None of the relevant information was contained in "Active Problems" but a great deal of irrelevant information was there!

The "Communications" section of SystmOne contains a chronological record of correspondence with the hospital, GP surgery and psychiatric units. However, the "Key Word Search" facility does not function at all and short of going through all of the correspondence there is no way of identifying the key information needed to undertake an effective risk assessment. The "Communications" section in Mr Goldstraw's case amounted to 83 pages. Although the relevant information concerning Mr Goldstraw's mental health issues was contained within the "Communications" section of SystmOne there was no way of easily extracting it.

Accordingly, a busy, under pressure rental health nurse or doctor is very likely to struggle to find the relevant entries using SystmOne, which may explain why (in Mr Goldstraw's case) too much reliance was placed on how he presented during interview. A prisoner who chooses not to disclose his true state of mind or suicidal ideation is unlikely to come to the notice of the healthcare staff whose job it is to identify the risk that he may pose to himself because SystmOne does not facilitate this.

There also appeared to be a lack of training in relation to the effective use of SystmOne. In particular, it was not clear whether any steps had been taken to ensure that the staff who were working at the prison at the time of Mr Goldstraw's death had been retrained or had their competencies assessed in light of the failures identified. There is a real concern that some staff are still failing adequately to carry out assessments of a prisoner's risk of suicide / deliberate self-harm.

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