Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil Ballard, a prisoner at HMP Risley, on 26 October 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Neil Ballard was found hanged in his cell at HMP Risley on 26 October 2022. He was 40 years old. I offer my condolences to his family and friends.

Mr Ballard had difficult telephone conversations with his sister a week before his death. Although this might have contributed to his decision to take his life, there is no evidence that he shared his concerns or distress with staff which meant they could not take action to support him.

However, staff did not have meaningful engagement with him in the weeks before he died. Had they done so, they might have had the opportunity to understand and address his increased risk of suicide.

The clinical review into Mr Ballard’s death concluded that his care was equivalent to that which he might have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **January 2024**

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Summary

Events

1. On 13 June 2022, Mr Ballard was remanded to HMP Liverpool, charged with threats to kill and aggravated stalking. He had been to prison before. He denied thoughts of suicide and self-harm and had no history of mental health issues. On 8 September, while at HMP Forest Bank, Mr Ballard was sentenced to one year and four months in prison. A month later, he was transferred to HMP Risley, where he spent just over two weeks before his death. Mr Ballard told staff he had no concerns about being there.

2. At Risley, Mr Ballard had frequent telephone contact with his sister. In a telephone call on 14 October, he told her that he did not leave his cell as he was worried that other prisoners might take his property and that he might "cop for it" when he was moved to a standard wing. He told her that he had heard that there may be some prisoners on the wing with whom he did not get on. He also asked whether it was worth carrying on with life. Prison staff recorded little about Mr Ballard during the ten days leading to his death.

3. On 19 October, Mr Ballard spoke to his sister several times. His final call to her appeared challenging and distressing for them both.

4. On 25 October, a mental health nurse spoke to Mr Ballard in his cell after he failed to attend for a well man screening appointment. Mr Ballard told the nurse he was okay and that he did not want to speak to him.

5. The operational support grade on duty carried out a routine check at 5.12am on 26 October. He said he saw Mr Ballard kneeling on the floor but assumed he was praying so was not concerned.

6. At around 8.42am on 26 October, officers found Mr Ballard in his cell, with a ligature tied around his neck and to his upturned bed. Although a code blue was not called, an officer radioed for assistance and explained that Mr Ballard had been found hanging. The control room therefore called for an ambulance as though a code blue had been called.

7. The officers and emergency response nurse initially tried to resuscitate Mr Ballard but stopped soon afterwards as it was clear that he was dead. Paramedics confirmed his death at 9.07am.

Findings

8. Mr Ballard did not have any significant risk factors for suicide and self-harm when he arrived at Risley and had never been monitored under suicide and self-harm prevention procedures, known as ACCT. Given what staff knew at the time, it was reasonable that he was not monitored.

9. During Mr Ballard's time at Risley, staff had no meaningful contact with him. Although we do not know whether Mr Ballard would have shared his concerns and anxieties with them, as he had done with his sister.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Ballard's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Ballard's clinical care at the prison.

13. The investigator interviewed nine members staff and one prisoner at HMP Risley, some jointly with the clinical reviewer.

14. We informed HM Coroner for Cheshire of the investigation. She provided us with a copy of the post-mortem and toxicology reports. We have sent the Coroner a copy of this report.

15. We contacted Mr Ballard's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She told us that other prisoners had bullied and threatened to sexually assault Mr Ballard at HMP Forest Bank, and that staff had taken no action following his allegations. Mr Ballard's sister also said that staff had never checked on her brother's welfare or offered him any support after she had reported to the prison that Mr Ballard had told her in telephone calls that he would take his own life. She said that that staff at Forest Bank had taken no action to tell staff at HMP Risley that he was vulnerable and suicidal and how she had raised concerns about his welfare. We have tried to address these concerns in this report.

16. Mr Ballard's sister received a copy of the initial report. She pointed out some factual inaccuracies. This report has been amended accordingly.

17. In response to the initial report, HMPPS pointed out some minor inaccuracies in the report. However, these do not impact on the overall factual accuracy of this report.

Background Information

HMP Risley

18. HMP Risley is a resettlement prison which holds over 1,000 convicted men. Greater Manchester Mental Health NHS Foundation Trust provides healthcare services in the prison. Change Grow Live provides substance misuse services. There is 24-hour healthcare cover.

HM Inspectorate of Prisons

19. Inspectors carried out a full unannounced inspection in June 2016. They noted that staff did not engage with prisoners positively and spent too much time in wing offices. They recommended that staff engage more regularly with prisoners.

20. In November 2020, inspectors carried out a short scrutiny visit. They reported the prison was well-led and the level of self-harm and violence had decreased. They reported that staff engaged well with prisoners, including through key work and that there were increased welfare checks for the most vulnerable prisoners. However, inspectors noted that prisoners without work were only let out of their cell for an hour a day and to collect meals which was not long enough. They recommended that time out of cells should be increased to enable purposeful activity.

21. Inspectors carried out a full unannounced inspection in April 2023. They reported that levels of self-harm were higher than at comparable prisons and that reasonable focus had been given to implementing PPO recommendations.

22. Inspectors noted that 68% of prisoners had reported being treated with respect by staff but some prisoners had described staff as dismissive and unhelpful and that officers tended to gather in groups rather than interacting with prisoners. Inspectors reported that prisoners had said that keywork was helpful and a small number of prisoners reported that they received good support from their keyworker.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for the year to April 2022, the IMB reported that overall, prisoners were treated fairly, relationships with staff were good and respectful and healthcare services were also good.

24. The IMB reported that a good level of support was offered to prisoners at risk of suicide and self-harm through ACCT monitoring and that there had been a steady decline in violence. The IMB reported that the case management of vulnerable prisoners, including of those who were self-isolating, was good.

Previous deaths at HMP Risley

25. Mr Ballard was the fourth prisoner to take his life at Risley since January 2020. Our investigation report into one of those deaths found a delay of four minutes before

calling an ambulance after a code blue was radioed. There have also been ten deaths from natural causes since January 2020, including two since Mr Ballard's death in March and August 2023. Our reports into two of these deaths identified staff's failure to call an emergency code immediately. We found no other significant similarities between our investigation findings in this report and those of our previous investigations.

Assessment, Care in Custody and Teamwork

26. ACCT is the Prison Service care planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise prisoners. As part of the process, a care plan which includes support and intervention, should be in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

HMP Liverpool

27. On 13 June 2022, Mr Ballard was remanded to HMP Liverpool, charged with threats to kill and aggravated stalking. It was not his first time in prison. During his initial health screen, Mr Ballard denied mental health issues and thoughts of suicide and self-harm.

28. On 17 June, Mr Ballard told staff that he had been in a fight with his cellmate. Staff moved him to another cell after he became distressed. The following day, a mental health nurse assessed him but found no evidence of any mental health concerns.

29. On 5 July, an intelligence report noted that Mr Ballard had received money from his cellmate and might be taking advantage of him.

30. On 25 July, Mr Ballard's legal team contacted the prison and said that he was being threatened and was at risk. The following day, staff spoke to Mr Ballard about this. He told staff he could hear people calling him a "nonce" but had not received direct threats and would not tell them the names of the perpetrators. Staff told Mr Ballard that this made it difficult to investigate the allegations. He told them that he understood. Mr Ballard was offered a move to another wing. He was told that if he continued to feel at risk, he could apply for vulnerable prisoner status. They reminded him of the support available and told him to tell them if he continued to feel unsafe.

HMP Forest Bank

31. On 11 August, Mr Ballard attended court, where he was convicted. He was transferred to HMP Forest Bank to await sentencing. A nurse completed his initial health screen but noted no significant health issues.

32. During his first night interview, Mr Ballard told staff that he was not a gang member and had no concerns in the community which might put his safety at risk in custody. He denied thoughts of suicide or self-harm.

33. On 12 August, during a prison induction, Mr Ballard was told how to access support from the Samaritans and Listeners (prisoners trained by the Samaritans to provide confidential and emotional support) and that if he felt unsafe, he could speak to staff. On 15 August, the prison chaplain introduced himself and offered support.

34. On 22 and 23 August, Mr Ballard's sister said she made eight telephone calls to the prison because she was concerned about his safety and welfare. She said that her brother had told her he was going to kill himself due to abuse from other prisoners. The safer custody team asked officers on his wing to check on him and note the outcome in his prison records.

35. On 25 August, an officer noted that a member of Mr Ballard's family had contacted the chaplaincy, concerned about him. (This likely refers to Mr Ballard's sister's contact in the preceding days.) An officer checked on Mr Ballard who said that he was worried for his safety, he would only leave his cell when necessary, he believed

there was a “price” on his head and, if necessary, would kill himself before anyone else got to him. The officer told the prison’s safer custody unit but there is no evidence that anything further was done to address this.

36. On 1 September, an officer noted that Mr Ballard had refused to work or attend education for two weeks. The officer did not note a reason for this.

37. On 8 September, Mr Ballard was sentenced to one year and four months imprisonment. Afterwards, officers checked he understood what had happened at court and asked if he wanted to discuss his sentencing or be assessed by a nurse. Mr Ballard declined.

38. On 23 September, an officer completed a key work session with Mr Ballard. The officer noted that he was well-mannered and appeared in good spirits. Mr Ballard said that he felt safe on his wing, he got on well with other prisoners and although it was noted that he took advantage of the regime offered to him, he said that he did not want to work or attend education. Mr Ballard said he had accepted his sentence and denied thoughts of suicide or self-harm. He said that his contact with family and friends helped to keep his spirits up in preparation for his release. He reassured the officer that he would tell staff if this changed and knew how to access support.

39. Mr Ballard’s sister told us that on 27 September, she made two telephone calls to the prison and two further calls the following day. (She sent us a record of her telephone contact. There is no mention of her calls in Mr Ballard’s prison records.)

HMP Risley

40. On 7 October, Mr Ballard was transferred to HMP Risley as a progressive move. A nurse completed an initial health screen and noted that Mr Ballard was polite, relaxed and denied mental health issues and thoughts of suicide or self-harm.

41. At his first night interview, staff noted that Mr Ballard had not previously been monitored under ACCT monitoring procedures. He told them that he had some gang affiliations and had self-isolated at Forest Bank but had no concerns about being at Risley. Mr Ballard said that his grandmother had died in December 2021, and staff contacted the prison’s mental health team so that he could access bereavement counselling. He was given a single cell on the induction wing.

42. On 8 October, Mr Ballard had an induction and was told about the services and support available. He said he did not need support.

43. On 10 October, an officer noted that Mr Ballard was interested in education and that she would explore this with him.

44. On 12 October, Mr Ballard spoke twice with his sister by telephone. He spoke about prison and domestic matters and said he was happy at Risley as he did not share a cell. He talked about his restraining order and previous substance misuse. He talked to her again the next day. He did not sound troubled or stressed during these calls. (Prisoners’ telephone calls are not routinely monitored by HMPPS. Prison staff were therefore not aware of the content of Mr Ballard’s telephone calls with his sister.)

45. On the morning of 14 October, Mr Ballard again spoke to his sister about family, friends and domestic matters. He told her that he was due to be moved from the induction wing to C Wing. He said he had not had much interaction with prison officers. He told her that he did not leave his cell as he was worried that other prisoners might take his property. He spoke about how he might "cop for it" on C Wing as he had heard there were prisoners on the wing with whom he did not get on. He said he would only know when he had moved and would let her know. Mr Ballard's sister told him not to worry.

46. Mr Ballard told his sister that he had nothing to "get out for" and he would have to "fight for his children". He expressed his anger towards an ex-partner and questioned whether it was worth carrying on with life. Mr Ballard also talked to his sister about being with his mother who had died. His sister told him to stop talking like that. During this part of their conversation, Mr Ballard sounded angry.

47. Later that day, Mr Ballard was moved to a single cell on C Wing.

48. On the morning of 19 October, Mr Ballard tried to call his sister four times but could not reach her. He left a message for her at 9.50am, sounding upset and asking her to give his love to a family member and his children. When he called her again at 10.23am, the call connected but he hung up.

49. Mr Ballard spoke to his sister again at 1.18pm for just over a minute. Mr Ballard told his sister, "I am on my own here." This was the last time he spoke to her.

50. Prisoner A, who had moved to C Wing on 14 October and lived in the cell next to Mr Ballard, said that Mr Ballard did not talk much to other prisoners. He said that Mr Ballard "just did not look right" and appeared depressed but that he had never spoken about self-harm. He said he told a Custodial Manager (CM) that the mental health team should see Mr Ballard as he was concerned about him. (The CM told the investigator that the prisoner had not spoken to her about Mr Ballard.)

51. On 25 October, a mental health nurse noted that Mr Ballard had not attended a routine well man screen. He went to Mr Ballard's cell that afternoon to complete the assessment, escorted by two officers.

52. Officer A told the investigator that he opened Mr Ballard's cell door and told him that a nurse from the mental health team had come to see him. He said that Mr Ballard told him that he was okay and did not need anything. He checked he was sure. He said that the mental health nurse explained to Mr Ballard that he had been asked to check on him. He repeated that he was fine. Officer B said that Mr Ballard had said he did not want to speak to the nurse.

53. The mental health nurse told the investigator that Mr Ballard pushed the cell door closed within seconds of it being opened, and just "smirked". He said Mr Ballard did not appear distressed but when he returned to his office, he spoke to a senior colleague who advised him to book a further appointment to see Mr Ballard and to raise his lack of engagement at the mental health team meeting the following day.

54. Prisoner A said that the mental health team had visited Mr Ballard but that he had shut his cell door on them. He told the investigator that he was a Listener and said he spoke to the officers and nurse and offered to speak to Mr Ballard but was told to

leave him. He said that he tried to knock on Mr Ballard's door that evening but got no response. (A CM confirmed that Prisoner A was not a Listener. Officers A and B and the mental health nurse said that Prisoner A never spoke to them about Mr Ballard.)

55. That day, Officer B was told he would be Mr Ballard's keyworker. At around 4.00pm, he locked Mr Ballard's cell door, and looked through the cell observation panel to check on him. At 4.28pm, an officer unlocked Mr Ballard's cell so he could leave to collect his evening meal. However, Mr Ballard remained in his cell.

56. At 4.32pm, Officer B returned to the cell to check that Mr Ballard had collected his meal. He said that Mr Ballard was sitting on his bed, watching television and he assumed that he had already done so. He briefly joked with Mr Ballard, who laughed in response.

57. At 6.49pm, the early evening roll check (a routine check, the primary purpose of which is to count and check the whereabouts of prisoners) was completed. Seventeen minutes later, an officer checked that the cells were locked.

58. At around 7.30pm, an Operational Support Grade (OSG) arrived on the wing for night duty and received a handover from an officer. No concerns were raised about Mr Ballard. It was his second ever night shift. CCTV footage shows that he carried out the roll check at 9.32pm. He completed further hourly checks of the wing throughout the night but was not required to check on Mr Ballard.

Events of 26 October 2022

59. At 5.12am on 26 October, the OSG shone his torch through Mr Ballard's cell observation panel during the roll check. He told the investigator that everything in the cell was okay, but Mr Ballard was kneeling or crouching on the floor of the cell, close to his toilet on the left-hand side. He thought that Mr Ballard was praying and was not concerned.

60. The OSG lingered around Mr Ballard's cell for about a minute. (He said this was because he had been adjusting the beam on his torch as sometimes it was difficult to get the light angled correctly to see clearly into cells.)

61. An officer then took over duty from the OSG, who left the wing at around 7.00am. She said that the OSG did not raise any concerns about Mr Ballard.

62. At around 7.30am, Officer B and another Officer C arrived on the wing.

63. At around 7.46am, Officer C unlocked some of the prisoners on the wing, including those who worked on the wing and those who needed to collect medication. (Mr Ballard's cell was not unlocked because he did not work and was not prescribed medication.)

64. At around 8.42am, a prison laundry orderly looked through Mr Ballard's cell observation panel to ask Mr Ballard if he had any laundry to give him. He told Officer B, who was nearby, that he could not get a response from Mr Ballard. The officer looked through the observation panel. The officer described the cell as ransacked and said he could not see Mr Ballard. The officer tried unsuccessfully to

open the cell door as there was an obstruction behind the door. He assessed the situation and closed the cell door for safety reasons as he was worried that the occupant may attack him. He had not realised at the time that it was Mr Ballard.

65. Officer B shouted to Officer C, who was close by, that the cell door appeared to be blocked. He asked her if the occupant had already been unlocked. Officer C said she had not unlocked the cell. She arrived at the cell soon afterwards. When she looked into the cell, she noticed that the bed had been upturned and Mr Ballard appeared to be standing behind it, at the back of the cell. It was then that she realised that he was hanging from a ligature, made from bedsheets, from the top of the bed. (Officer B recalled that Mr Ballard was sitting in an upright position but was obscured by the bed.)

66. Officer C immediately unlocked the cell door and had to push her way in because the cell door was blocked by mattresses. Officer B radioed for staff assistance and said that a prisoner had been found hanging. He did not call a medical emergency code blue (used when a prisoner is unresponsive or has breathing difficulties). He then went into the cell and Officer B followed.

67. Although a code blue was not called, the control room operator was told that a prisoner was hanging and noted in the control room log that an ambulance had been called at 8.43pm. (However, ambulance records noted that the call was not made until 8.48am.)

68. Officer B, with the assistance of Officer C and the prison laundry orderly, cut the ligature and laid Mr Ballard on the floor of the cell. Officer D arrived and assisted. The officers checked for signs of life but found none. They said that Mr Ballard was cold and rigor mortis had set in. Officer C said she instinctively started cardiopulmonary resuscitation (CPR), assisted by Officer D.

69. A nurse responded and arrived at the cell with emergency equipment within a couple of minutes. She said that it was clear that Mr Ballard had died but she continued CPR out of instinct before she stopped. A prison paramedic and other healthcare staff arrived shortly afterwards. Ambulance paramedics arrived at 9.01am and Mr Ballard was pronounced dead at 9.07am.

Information received after Mr Ballard's death

70. A CM told the investigator that, on 28 October, an anonymous note was left in the wing's application box. The note stated that Prisoner A and another prisoner on C Wing had been bullying Mr Ballard before his death and had been shouting things from the window every night. An intelligence report was submitted after the note was found and Prisoner A was subsequently transferred to another prison.

Contact with Mr Ballard's family

71. At 11.10am on 26 October, the Acting Governor and a family liaison officer, broke the news of Mr Ballard's death to his sister. Risley contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

72. The CM who managed B wing, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support. However, the emergency response nurse was not invited to attend the hot debrief and was not offered support after Mr Ballard's death.

73. The prison posted notices informing other prisoners of Mr Ballard's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Ballard's death and offered support to other prisoners and staff.

Post-mortem report

74. A post-mortem examination found that Mr Ballard died from hanging. Post-mortem toxicology results found alcohol in his system but noted that although he might have had alcohol before he died, it might equally have been produced after his death. The report noted that the findings were not pathologically significant and concluded that there was no evidence that alcohol or any other drugs were directly implicated in Mr Ballard's death.

Findings

Assessment of Mr Ballard's risk

75. PSI 64/2011 on safer custody requires staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

76. Mr Ballard was not subject to ACCT monitoring during the two weeks he was at Risley. He did not have any significant risk factors when he arrived and had no known history of attempted suicide, self-harm, or mental health issues. However, before he was transferred to Risley, he became anxious about his safety at Forest Bank and shared these concerns with staff. They were not shared with Risley when he transferred.

77. In telephone conversations with his sister while at Risley, Mr Ballard talked about his future and concerns about other prisoners there. On 14 October, he told her that he did not want to leave his cell because he was frightened of other prisoners. He also expressed anger about his circumstances, questioned whether it was worth carrying on with life and talked about being with his mother who had died. During a further telephone call with her on 19 October, Mr Ballard sounded distressed about the breakdown in their relationship.

78. While this might have contributed to his decision to take his life, there is no evidence that he shared either his concerns for his safety, or his distress about his personal circumstances with staff at Risley and they could not, in the circumstances, reasonably have known that he was at imminent risk of suicide. In the days before his death, Mr Ballard did not display any behaviour that would have indicated that he was at a particular risk of suicide or self-harm, he did not present with any new risk factors and none of the prison or healthcare staff whom we interviewed considered that he was at an increased risk of suicide or self-harm.

79. With the information available to them, staff at Risley reasonably concluded that Mr Ballard did not need to be monitored under ACCT procedures.

Concerns for Mr Ballard's safety

80. Being a victim of intimidation or violence is a recognised risk factor for suicide and self-harm. The PPO has published a range of publications identifying the links between bullying and suicide and we identified the need for staff to record and investigate all reports or suspicions that a prisoner is being threatened or bullied and to consider the potential impact on the victim's risk of suicide.

81. Although Mr Ballard self-isolated for a short time at Forest Bank because he feared that he was under threat, and he told his sister in a phone call while at Risley that he did not want to leave cell in case his property was taken, we found no evidence that staff had or should have been aware of any threats against him prior to his death.

Clinical care

82. The clinical reviewer concluded that the healthcare that Mr Ballard received in custody was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.

Director to note – HMP Forest Bank

83. In August 2022, Mr Ballard's sister raised significant concerns with Forest Bank about her brother's safety after he had told her that he was thinking of taking his life. When staff checked on him, Mr Ballard confirmed that he was worried about his personal safety. While we recognise Mr Ballard's sister's comment that Mr Ballard had been threatened with sexual assault at Forest Bank, we found no evidence of this in the prison records. However, we know from prison records that he self-isolated in his cell for two weeks in August 2022.

84. We have seen no evidence to connect Mr Ballard's death to potential experiences at Forest Bank and we know that staff shared his concerns with the safer custody team. However, we saw no evidence that the safer custody team at Forest Bank took any subsequent action to investigate or address Mr Ballard's concerns. There was no evidence that the security unit considered Ballard's safety concerns and little evidence that welfare checks were completed for Mr Ballard or that he was offered any support.

85. Staff did not consider ACCT monitoring for Mr Ballard when he shared information with an officer about his thoughts of taking his life. This was a missed opportunity to assess his risk of suicide and self-harm. There was no evidence that staff considered closer monitoring after he shared his concerns and while he self-isolated.

Governor to note – HMP Risley

Meaningful interaction with staff

86. We consider that staff at Risley reasonably concluded that Mr Ballard did not need to be monitored under ACCT procedures. However, there was little evidence that they had any meaningful contact with him. None of the staff we interviewed had had significant contact with Mr Ballard and in one conversation with his sister, he told her that he had not had much interaction with them.

87. Staff need frequent and meaningful contact with prisoners to assess their risk properly, particularly during their early days in custody or in a new prison. Although we cannot know whether Mr Ballard would have shared his anxieties with staff, his prison records indicate that he had done so at previous prisons. HMIP also identified some concerns about the level of meaningful staff interaction with prisoners in their last two full inspections.

Cut-down tools

88. Officer B told the investigator that he had had not been trained to use a cut-down tool (used to cut ligatures in life-threatening situations). All staff should be confident in using one.

Emergency response

89. PSI 03/2013 on medical emergency response codes sets out that if an emergency code is radioed, an ambulance must be called immediately. Officer B radioed for assistance and stated that a prisoner had been found hanging but did not call a code blue as he should have done. Although a code blue was not called, the control room operator noted that the incident was a code blue and called for an ambulance.

90. Officer B told the investigator that he was aware that he should have called an emergency code blue. As he explained the situation fully, the control room appropriately prioritised the request for assistance as an emergency code blue and we therefore make no recommendation about this.

91. Although the control room noted that an ambulance was called at 8.43am, ambulance records indicated that one was not called until 8.48am. We have not been able to establish which of the timings was most accurate. We have previously raised concerns about delays in calling an ambulance at Risley and so we bring this to the Governor's attention.

Hot debrief

92. The emergency response nurse was not invited to attend the hot debrief and was not offered support after Mr Ballard's death.

Inquest verdict

93. The inquest hearing into the death of Mr Ballard was held on 30 September 2024. It confirmed the medical cause of Mr Ballard's death as hanging. The inquest concluded that Mr Ballard died by suicide.

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