Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason McQuoid, a prisoner at HMP Risley, on 2 March 2021

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 His Majesty's 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 Jason McQuoid died from hypoxic-ischaemic brain injury after he was found hanging in his cell on 2 March 2021, in the Care and Separation Unit at HMP Risley. He was 37 years old. I offer my condolences to his family and friends.

Mr McQuoid had been in prison before. He had a history of substance misuse, but no particular mental health concerns and no known history of suicide attempts or self-harm.

A few weeks after he moved to Risley, Mr McQuoid's mental health deteriorated. Over the space of five days, he displayed paranoid and bizarre behaviour, set a fire in his cell, was restrained and segregated in the Care and Separation Unit, was monitored under suicide and self-harm prevention procedures and, ultimately, died. Before he died, Mr McQuoid said he had used psychoactive substances, but his behaviour seemed to have returned to normal.

Clearly, some of the decisions made about Mr McQuoid in the days before his death were finely balanced and staff were dealing with some conflicting information. However, I am concerned that overall, there simply is not enough evidence to satisfy me that those decisions were made on the basis of all of the available evidence. There were missed opportunities for staff across various functions to assess Mr McQuoid's risk and provide him with appropriate support.

I am concerned that Mr McQuoid's mental health was not assessed despite his concerning behaviour, and that staff relied too much on his admission of illicit drug use and his assurances that he had no thoughts of suicide. The clinical reviewer concluded that the care Mr McQuoid received at Risley was of a mixed standard and not fully equivalent to that which he could 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 **August 2023**

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Summary

Events

1. On 27 November 2020, Mr Jason McQuoid was sentenced to 11 months in prison for theft while subject to a supervision order. Mr McQuoid had a history of substance misuse issues. He had been in prison several times before. Mr McQuoid was initially held at HMP Altcourse, but on 20 January 2021, he was transferred to HMP Risley.

2. In February, Mr McQuoid's mental health started to deteriorate. Staff began suicide and self-harm prevention procedures, known as ACCT, but stopped monitoring the next day. Mr McQuoid denied any intent to harm himself or that his behaviour was the result of illicit drug use. Prison staff referred him to the mental health team for further assessment.

3. Mr McQuoid appeared paranoid and believed that other prisoners were going to attack him. Staff tried to reassure him, but his behaviour remained unchanged. Staff considered that he did not pose an increased risk to himself.

4. On 27 February, Mr McQuoid set fire to his cell. Staff tried to remove him from the cell, but he resisted. They restrained him and moved him to the Care and Separation Unit (CSU). Staff began ACCT monitoring again. The CSU was very rowdy that night and so staff placed him under constant supervision on a different wing overnight.

5. Mr McQuoid moved back to the CSU first thing the next morning. Some of the paperwork explaining the decision to segregate him despite him being subject to ACCT procedures was either missing from the investigation paperwork or incorrectly completed.

6. During an ACCT review on 28 February, Mr McQuoid told staff that he had no recollection of the events of the night before and that he had been under the influence of a psychoactive substance (PS) at the time. He denied any thoughts or intent to harm himself. Staff reduced his observations to hourly and planned to discuss his care with the mental health team.

7. On 1 March, Mr McQuoid was found several times with his mattress placed behind his cell door. On each occasion staff asked him to remove it, which he did.

8. At 12.55am on 2 March, during an ACCT check, an officer found Mr McQuoid hanging from his cell window. The officer immediately radioed for assistance, but he did not use a medical emergency code. The officer waited for other staff to arrive, and they entered the cell and removed the ligature from around Mr McQuoid's neck. A nurse asked staff to call an ambulance. Staff began cardiopulmonary resuscitation (CPR). Paramedics arrived at 1.10am and took over Mr McQuoid's care and treatment.

9. Mr McQuoid was taken to the intensive care unit at hospital, where he died later on 2 March.

Findings

10. The clinical reviewer concluded that the care Mr McQuoid received at Risley was of a mixed standard and not fully equivalent to that which he could have expected to receive in the community.

11. When Mr McQuoid arrived at Risley, he asked staff to refer him to the mental health team. There is no evidence that healthcare staff actioned this. When staff became concerned about Mr McQuoid's mental health, a duty mental health nurse failed to conduct an urgent mental health assessment for Mr McQuoid. Instead, he told staff to start ACCT procedures. This was not an appropriate response.

12. There were missed opportunities to consider Mr McQuoid's risk in the round. Instead, staff were too easily reassured by his admission that he had used illicit drugs and had no thoughts of suicide or self-harm.

13. It is not clear that the decision to segregate Mr McQuoid under ACCT procedures was appropriate and compliant under the relevant prison policy because relevant paperwork was either not available to the PPO or incorrectly completed.

14. The substance misuse team should have been told that Mr McQuoid had used PS given that they were already working with him. They should also have been involved in the ACCT process.

15. The officer who found Mr McQuoid hanging in his cell, failed to use a medical emergency code. As a result, there was a delay of four minutes in calling an ambulance.

Recommendations

- The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including:
    - that prison and healthcare staff share all information that affects risk and do not rely solely on what a prisoner says or how he presents and
    - consider whether the prisoner's family should be involved in the ACCT process, discuss this with the prisoner, and document the outcome of any discussions.
- The Governor and Head of Healthcare should ensure that:
    - All necessary paperwork explaining the decision to segregate is appropriately completed, stored and made available in the event of a PPO investigation.
- The Head of Healthcare and the Mental Health Team Manager should ensure that:
    - mental health referrals are actioned and recorded, and assessments take place with appropriate urgency.

- ACCT procedures are not used to substitute urgent mental health assessments.

- The Governor and the Head of Healthcare should ensure that:
  - any information suggesting a prisoner has or is at risk of substance misuse is shared with the substance misuse service, and
  - the substance misuse service are invited to ACCT reviews as appropriate.
- The Governor should ensure that all staff use the medical emergency codes as set out in PSI 03/2013.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded and provided information, which was considered as part of the investigation.

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

18. The investigator interviewed 11 members of staff between 21 and 23 April 2021. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic. The investigation was subsequently transferred to one of the investigator's colleagues, who completed the investigation.

19. NHS England commissioned a clinical reviewer to review Mr McQuoid's clinical care at the prison. He completed joint interviews with the investigator.

20. We informed HM Coroner for Cheshire of the investigation. The Coroner gave us the post-mortem report and toxicology reports. We have sent the Coroner a copy of this report.

21. The Ombudsman's family liaison officer contacted Mr McQuoid's family, to explain the investigation and to ask if they had any matters, they wanted us to consider. The family asked the following questions:

    - How long had Mr McQuoid lived on the rehabilitation wing?
    - Was Mr McQuoid prevented from communicating with his family at any point?
    - On 26 February, his mother received a phone call from the prison asking her if she was all right as Mr McQuoid was anxious. Why was Mr McQuoid not allowed to make the call himself?
    - Was Mr McQuoid under pressure from other prisoners?
    - Did Mr McQuoid receive items sent to him by his family?
    - What was Mr McQuoid's mental health like and what care was he receiving?
    - Why did it take the prison over 5 hours to notify them that Mr McQuoid had tried to take his own life?
    - Why did Mr McQuoid set fire to his cell on 27 February?
    - What attempts were made to resuscitate Mr McQuoid and how long was it before an ambulance was called?

22. Mr McQuoid's family asked some questions which were outside the remit of our investigation. We have responded to the family about those questions in separate correspondence.

23. Mr McQuoid's family responded to our initial report and raised further questions in relation to the findings. These have been answered in separate correspondence.

24. HMPPS responded to our initial report and highlighted one factual inaccuracy, in relation to the healthcare provider, this has been amended. HMPPS also provided an action plan in response to the recommendations made. This is attached as an additional annex.

25. Following an inquest into Mr McQuoid's held on 7 October 2024, the assistant Coroner for Cheshire concluded that:

    '… a lack of a robust handover procedure and the observations (ACCT) not carried out irregularly to the stated frequency, on the balance of probability did contribute more than minimally to Mr McQuoid's death …'

    '… on reception assessment there was a failure to refer Mr McQuoid for mental health team intervention, which possibly contributed to Mr McQuoid's death …'

Background Information

HMP Risley

26. HMP Risley is a medium security training prison which holds over 1,000 convicted men. Greater Manchester Mental Health NHS Foundation Trust provides primary healthcare and mental health care services in the prison. Change Grow Live provide substance misuse services. There is 24-hour healthcare cover.

HM Inspectorate of Prisons

27. The most recent full inspection of HMP Risley was in June 2016. In November 2020, HMIP carried out a short scrutiny visit to review the conditions at Risley and treatment of prisoners during the COVID-19 pandemic. They found that the amount of violence and self-harm had reduced at the start of the restrictions. There had been a subsequent rise in the number of incidents, but this remained below pre-pandemic levels. This was in the context of improved prison safety and reducing trends in both violence and self-harm in the year before the pandemic. Safety meetings had continued throughout the pandemic and managerial oversight of this area was good.

28. Inspectors found evidence of an appropriate level of support for prisoners at risk of suicide or self-harm, supported by the ACCT case management process. They saw staff engaging well with prisoners. Key work had been well embedded in the prison before the pandemic, and weekly checks on the wellbeing of more vulnerable prisoners and those coming up for release had continued during the COVID-19 pandemic.

Independent Monitoring Board

29. 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 latest annual report for the year to March 2021, the IMB reported a good level of support for prisoners.

Previous deaths at HMP Risley

30. Mr McQuoid was the sixth prisoner to take his own life at Risley since March 2018.

31. In a previous investigation into the death of a prisoner at Risley in August 2020, we made recommendations about the substance misuse and mental health care. The prison accepted our recommendation and said that to ensure a collaborative approach, there would now be a fortnightly meeting between departments. It is disappointing that we are raising this issue again in this report.

Assessment, Care in Custody and Teamwork

32. 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 the prisoner. After an assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

33. As part of the process, a caremap (plan of care, support, and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive substances

34. Psychoactive substances (PS), previously known as 'legal highs', are an increasing problem across the prison estate. They are difficult to detect and can affect people in several ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

35. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

36. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

HMP Altcourse

37. On 27 November 2020, Mr Jason McQuoid was sentenced to 11 months in prison for theft while subject to a supervision order and was sent to HMP Altcourse. This was not his first time in prison. Mr McQuoid had a history of substance misuse in prison and in the community. He sometimes reported having been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) as a child but had not been prescribed medication for some years. He generally reported no history of suicide attempts or self-harm either in prison or the community.

38. During his health screen at Altcourse, Mr McQuoid tested positive for cocaine, opiates, benzodiazepines, and cannabis. He told healthcare staff that he had spent around £100 per day on drugs and had used two bags of heroin before he had been taken into police custody two days earlier. Healthcare staff referred him for support from the Integrated Drug Treatment Service (IDTS) and they started him on a methadone programme. (Methadone is a drug commonly used for the treatment of withdrawal associated with opiate addiction). Mr McQuoid denied having mental health issues or thoughts of suicide or self-harm. There were no significant issues during Mr McQuoid's period at Altcourse.

HMP Risley

39. On 20 January 2021, Mr McQuoid was transferred to Risley. When he arrived, a nurse completed his health screen. He noted that Mr McQuoid was on a methadone programme. Mr McQuoid asked to be referred to the mental health team and to see a GP. He told the nurse that he had seen his friend being killed during a fight in the community and that he had 'flashbacks and nightmares'. There is no evidence that a nurse made the referrals, and he did not record any other issues about Mr McQuoid's mental or physical health.

40. An officer completed Mr McQuoid's first night interview. He noted that Mr McQuoid was polite, cheerful, and denied thoughts of harming himself. Mr McQuoid completed his period of COVID-19 quarantine in B wing on 4 February and remained there because he was under the care of the substance misuse service.

41. On 8 February, Mr McQuoid met his prison offender manager. He recorded that Mr McQuoid appeared happy to be at Risley and was due to be released in June but was unsure where he would live after his release. He told him that he would see him again to discuss his concerns about his release.

42. On 25 February, an officer recorded that Mr McQuoid was self-isolating because other prisoners were calling him a 'nonce'. (Nonce is a derogatory term used to describe anyone convicted of sexual offences.) Mr McQuoid believed that staff were leaving his door unlocked so that other prisoners could enter his cell and attack him. Staff considered that Mr McQuoid was behaving bizarrely, and they referred him to the mental health team for assessment. Mr McQuoid's strange behaviour continued that day. He shouted at other prisoners through his cell door, telling them that he was not a 'nonce' but they were.

43. On the morning of 26 February, prison and healthcare staff attended a Safety and Intervention Meeting (SIM – a joint meeting between custodial and healthcare staff) to discuss prisoners of concern, including Mr McQuoid. Staff said that his behaviour was now affecting other prisoners.

44. That afternoon, an officer spoke to mental health nurse about Mr McQuoid. She asked for someone from the mental health team to see him. The nurse documented in Mr McQuoid's medical record that he had told the officer that mental health staff "don't just come and see prisoners" and that even though there was a mental health duty worker who completed urgent reviews, prison staff should start suicide and self-harm prevention procedures, known as ACCT, if they were concerned. He said that a member of the mental health team would attend the first ACCT case review and have a multidisciplinary meeting to address Mr McQuoid's issues. He also noted that he had told the officer to refer Mr McQuoid to the mental health team for discussion at the weekly Single Point of Referral meeting (a mental health team meeting to discuss those prisoners who have been referred to the service).

45. Later that afternoon, prison staff started ACCT monitoring because Mr McQuoid was behaving erratically (although he had not harmed himself or expressed any intention to do so). A Supervising Officer (SO) completed the immediate action plan. He told the investigator that he knew Mr McQuoid from previous periods at Risley, but he had not seen him display paranoid behaviour before. He said that in the past, Mr McQuoid had been known to use PS and he initially thought that Mr McQuoid's behaviour was drug related.

46. Staff completed an assessment interview shortly afterwards. This was immediately followed by a case review, chaired by a SO. A mental health nurse, and a member of the chaplaincy team also attended. They agreed that ACCT monitoring should stop because Mr McQuoid did not pose an immediate risk to himself and had said that he had no thoughts of self-harm. The SO said that although ACCT monitoring ended, Mr McQuoid remained in the post-closure phase for seven days and wing staff were aware of his behaviour and issues. The nurse questioned whether Mr McQuoid's presentation was the result of PS use. The SO said that he did not believe that it was. There is no evidence that the nurse considered that Mr McQuoid needed any mental health support.

47. A SO telephoned Mr McQuoid's mother on his behalf while the review was taking place to reduce Mr McQuoid's anxiety. She asked the SO to ask Mr McQuoid to contact his grandmother, which he did. There is no evidence that the staff at the ACCT case review considered involving Mr McQuoid's family in the process.

48. The SO spoke to wing staff to find out if they had observed anything to confirm Mr McQuoid's perception that he was under threat. Wing staff told him that they were not aware of any incidents or threats directed toward Mr McQuoid and that staff had not seen any prisoners going to his cell.

49. At 4.50pm on 27 February, Mr McQuoid started a fire in his cell. Staff tried to get him to leave the cell, but he resisted. They restrained him and took him to the Care and Separation Unit (CSU). Mr McQuoid began to shout about an offence that he had previously committed and said that it was not a sexual offence. Staff considered that he was displaying paranoid behaviour again. The Head of Safer

Custody agreed that Mr McQuoid should be subject to constant supervision because he had set a fire in his cell. She said that the CSU was very rowdy that evening and so she agreed he could be placed in a constant supervision cell on E wing and return to the CSU the following morning. (A constant supervision cell has a gate covered in Perspex, rather than a solid door, so that staff can watch over the prisoner. A member of staff is positioned at the gate at all times to observe the prisoner.)

50. As Mr McQuoid was in the post-closure phase of his ACCT, staff restarted ACCT procedures. On the morning of 28 February, Ms Matthews authorised Mr McQuoid to be held in the Care and Separation Unit while subject to ACCT procedures. She told us that he was to be held under Prison Rule 53 (where a prisoner is to be charged with an offence against discipline at an adjudication hearing) because he had endangered the lives of staff, other prisoners and himself by setting fire to his cell. He had also resisted staff attempts to remove him from the cell for his own safety. We have not seen the decision log the head of safer custody said she completed to record why she thought he should be segregated.

51. At 9.10am on 28 February, a mental health nurse completed a health screen to assess whether Mr McQuoid had any mental or physical health concerns that meant he should not be segregated in the CSU. The nurse incorrectly recorded that Mr McQuoid was not subject to ACCT procedures. The nurse recorded that Mr McQuoid was fit to be segregated.

52. At 9.15am on 28 February, the head of safer custody chaired an ACCT case review. A nurse and a member of staff from the chaplaincy team attended. She asked Mr McQuoid about starting the fire in his cell. Mr McQuoid said that as soon as he arrived on B wing, someone gave him spice (PS) which had made him ‘lose his head’. Mr McQuoid also said that he could not remember anything about what happened the day before. She told the investigator that Mr McQuoid presented as settled, he was talking coherently and did not report hearing voices. she asked whether he had thoughts or intent to harm himself and Mr McQuoid said, ‘Definitely no’. He said that he was due to be released in June and had two children so would never do that.

53. The meeting considered that Mr McQuoid had an issue with PS. He told the reviewers that he was happy to be in the CSU and away from drugs. The Head of Safer custody said that she knew that Mr McQuoid was engaging with the substance misuse team. She asked him if being away from PS would cause him any negative issues such as detoxification symptoms. Mr McQuoid said no and that he never had issues like that.

54. The Head of Safer Custody said that Mr McQuoid’s presentation was the opposite of how he had presented the day before, and it was not in keeping with the comments made in the ACCT document overnight, which said that Mr McQuoid had displayed bizarre behaviour. The case review team asked Mr McQuoid several times if he had thoughts of self-harm, which he continually denied. He talked about his children who were protective factors. The attendees at the meeting believed that the effects of whatever he had taken had worn off. She said that Mr McQuoid was rational and that they had no concerns about his presentation. Mr McQuoid asked whether being convicted of slapping a girl’s bottom would class him as a sex

offender. She told him that he was not in prison for sexual offences so was not a sex offender. The case review team reassured him that he was safe.

55. She asked a nurse what level of observations he felt were appropriate based on what they had discussed and Mr McQuoid's presentation during the meeting. The nurse said that hourly observations would be appropriate. A member of staff from the chaplaincy team and the head of safety custody agreed. The case review team decided that Mr McQuoid would be reviewed on 3 March as the mental health team were due to discuss him that day at their weekly meeting and this would also allow a member of the substance misuse team to attend.

Events of 1 and 2 March

56. At 2.55pm on 1 March, a nurse completed another segregation health screen. She noted that Mr McQuoid was subject to ACCT procedures but did not think his mental health would deteriorate if he remained segregated. She concluded that he was safe to remain in the CSU.

57. On 1 and 2 March, an officer was on night duties in the CSU. CSU staff had told him about Mr McQuoid and his belief that he was at risk from other prisoners. They also told him that during the day, Mr McQuoid had moved his mattress several times from his bed and placed it behind his door. We have no information about whether staff tried to discuss this with Mr McQuoid or understand his behaviour.

58. The officer completed hourly observations in line with the ACCT document. On some occasions when he checked on Mr McQuoid, he had moved his mattress from his bed and placed it behind his cell door. When he asked him to move it back, he did so straight away and raised no concerns. The officer said that he did not have any significant conversations with Mr McQuoid but on some occasions when he completed his checks, Mr McQuoid acknowledged him by saying, 'Alright boss,' and on other occasions, he gave a 'thumbs up' gesture. The officer described Mr McQuoid's presentation as normal.

59. At 11.00pm on 1 March, the officer recorded in Mr McQuoid's ACCT document that he had been standing at his sink, washing his face and he did not report any concerns. At 11.59am, the officer completed another check and saw Mr McQuoid sitting on his mattress behind his door. The officer asked him to put it back on his bed and Mr McQuoid did so.

60. At 12.55am on 2 March, the officer checked on Mr McQuoid again. He looked through the observation panel of his cell and saw him hanging with a ligature around his neck, tied to the window. The officer radioed for assistance, but he did not use a medical emergency code. The officer said that because he was on his own, he did not enter the cell immediately.

61. A Custodial Manager (CM), and a nurse and other prison staff responded. When they arrived at the cell, the officer opened the door and went in. He released the ligature from around Mr McQuoid's neck and placed him on the floor. The nurse checked for a pulse and any signs of breathing and asked the staff to call an ambulance immediately, this was four minutes after the officer had discovered Mr McQuoid hanging. Staff attached a defibrillator to Mr McQuoid and started CPR until paramedics arrived at 1.10am, took over his care and took him to hospital.

62. A CT scan showed that Mr McQuoid had no brain activity. He was placed on life support in the Intensive Care Unit (ICU), where he died at 4.15pm on 2 March.

Contact with Mr McQuoid's family.

63. At 2.35am on 2 March, a CM tried to telephone Mr McQuoid's mother to let her know that her that her son had been taken to hospital, but she did not answer the phone. He left a message asking her to contact the prison.

64. Address details were provided by the prison to police at around 4.10am, and police visited the family home and informed them that they should attend the hospital.

65. The prison appointed an officer as the prison family liaison officer (FLO). At 9.30am on 2 March, he went to the hospital, where he met Mr McQuoid's parents. After Mr McQuoid died, the FLO spoke to the family and provided ongoing support.

66. The prison offered a financial contribution towards the cost of the funeral in line with national policy.

Support for prisoners and staff.

67. After Mr McQuoid's death, the CM 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.

68. The prison posted notices informing other prisoners of Mr McQuoid's death and offered support to those who might need it. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case Mr McQuoid's death had adversely affected them.

Post-mortem report

69. The Coroner concluded in the post-mortem that Mr McQuoid died of hypoxic-ischaemic brain injury caused by cardiac arrest and hanging. Post-mortem toxicology samples found no illicit substances in Mr McQuoid's system.

Findings

Identification and management of Mr McQuoid's risk of suicide and self-harm.

70. Mr McQuoid had been in prison since November 2020, without raising any significant concerns about his mental health or risk of suicide and self-harm. Within the space of five days, his mental health had deteriorated, he had set a fire in his cell, been restrained, and moved to the Care and Separation Unit, been monitored under ACCT procedures, including in a constant supervision cell, had admitted using PS and, ultimately, had apparently taken his life. We have considered whether staff at Risley appropriately identified and managed his risk of suicide and self-harm.

71. PSI 64/2011 lists a number of risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide and self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Mr McQuoid had some risk factors, including a history of substance misuse, and the current context of anxiety, paranoia, and bizarre behaviour.

72. On 26 February, staff began ACCT monitoring after they became concerned that Mr McQuoid was behaving bizarrely and displaying paranoid behaviour. They did not, in fact, consider that he posed a particular risk of suicide and self-harm but had received little support from the mental health team (discussed in more detail in a separate section). Mr McQuoid assured them that he had no thoughts of suicide or self-harm and so staff ended ACCT monitoring later that day.

73. On 27 February, Mr McQuoid set fire to his cell and would not leave the cell when instructed to do so, so staff began ACCT monitoring again. In response to this escalation in his erratic behaviour, staff constantly supervised him.

74. At all times, Mr McQuoid maintained that he had no thoughts of suicide or self-harm. He claimed to have taken PS and have no memory of his actions. He described his children as important reasons to stay alive. On 28 February, staff concluded that his level of risk could be sufficiently managed by one check an hour.

75. We consider that staff were correct to begin ACCT monitoring when they became concerned about Mr McQuoid's mental health and in response to his strange and risky behaviour. However, we are concerned that they were too quickly reassured (both by what he told them and because his behaviour seemed more normal) and reduced levels of observations by too much, too soon. In fact, they still had relatively little insight into what had caused Mr McQuoid's bizarre presentation: he said he had taken PS, but he had not been fully assessed by the mental health team.

76. Mr McQuoid continued to display concerning behaviour on 1 March, when he placed his mattress behind his cell door several times throughout the day and night, despite staff telling him not to. There is no evidence that staff tried to talk to Mr McQuoid about why he was doing this, or that they considered whether it indicated his level of risk had increased. We consider that this was a relatively finely balanced

decision but concluded that staff could have viewed his risk more holistically and relied less on his presentation and reassurances that he was fine.

77. On 26 February, the SO chairing Mr McQuoid's ACCT case review telephoned Mr McQuoid's mother to help to ease his anxiety. Mr McQuoid had expressed concerns about the safety of members of his family and we consider that staff should have asked Mr McQuoid if he would have liked his family to be involved in the ACCT process, as directed by PSI 64/2011. It is possible that they could have helped staff to understand Mr McQuoid's presentation and level of risk. We recommend:

The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including:

- **that prison and healthcare staff share all information that affects risk and do not rely solely on what a prisoner says or how he presents, and**
- **consider whether the prisoner's family should be involved in the ACCT process, discuss this with the prisoner, and document the outcome of any discussions.**

Mr McQuoid's location in the CSU

78. Prison Service Order (PSO) 1700, Segregation, sets out the process that must be followed and actions that should be taken when a prisoner is located in segregation. In relation to those prisoners subject to ACCT monitoring, PSO 1700 says:

'…A prisoner on an open ACCT must only be kept in segregation under exceptional circumstances whereby they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate…'

79. On 27 February, Mr McQuoid started a fire in his cell. It is not clear that staff established why he had done so and whether, for example, he intended to harm himself in the process. For obvious reasons, setting fires in prison is punishable through the adjudications process and Mr McQuoid was taken to the CSU pending an adjudication. Soon after Mr McQuoid was moved to a constant supervision cell on E wing, but it seems that staff always intended to move him back to the CSU as soon as possible. We have considered whether the decision to segregate him while on an ACCT was appropriate.

80. The head of safety custody said that she completed a justifiable decision log to record her reasons for segregating Mr McQuoid. Despite asking for a copy of this, we did not receive one. Almost as soon as he moved back to the CSU from E wing on 28 February, the staff at the ACCT case review concluded that his risk to self-had reduced and he was behaving quite normally. We understand that Mr McQuoid was considered a risk to staff and prisoners having set a fire in his cell. She told us that she considered the CSU was the most appropriate place to hold Mr McQuoid until staff had been able to speak to him and identify his needs. However, there is no evidence that those present at the ACCT case review (including the Head of Safety Custody) reconsidered his location after the ACCT review.

81. A nurse completed the first segregation health screen on 28 February, but incorrectly noted that Mr McQuoid was not subject to ACCT procedures. A second health screen completed on 1 March concluded that Mr McQuoid could be safely segregated.

82. Mr McQuoid said he was quite happy to be in the CSU and raised no particular concerns with CSU staff or healthcare and chaplaincy staff who made routine visits to the unit while he was there.

83. However, we are unable to say that the decision to segregate Mr McQuoid was wholly reasonable and in line with PSO 1700. There is insufficient documentary evidence that staff properly considered whether there were any alternatives, and we are not satisfied that the original health assessment was appropriate. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **All necessary paperwork explaining the decision to segregate is appropriately completed, stored, and made available in the event of a PPO investigation.**

Mr McQuoid's mental healthcare

84. The clinical reviewer concluded that the mental healthcare Mr McQuoid received at Risley was of a mixed standard and not fully equivalent to that which he could have expected to receive in the community. According to his prison medical record, Mr McQuoid had no significant mental health needs and had not needed support from mental health teams during previous prison stays.

85. However, when Mr McQuoid arrived at Risley on 20 January 2021, he asked to be referred to the prison's mental health team. The clinical reviewer found no evidence that a referral was made and considers that this was a missed opportunity to identify any mental health concerns that Mr McQuoid might have had at an early stage.

86. On 25 February, prison staff referred Mr McQuoid to the mental health team because they were concerned about his strange behaviour. On 26 February, they asked a mental health nurse to come and see Mr McQuoid. That nurse told them to begin ACCT monitoring instead and that a mental health nurse would attend the first ACCT case review. This was an inappropriate and unhelpful response. The clinical reviewer highlighted that this was another missed opportunity to conduct an urgent mental health assessment, which should have fed into the ACCT process. We recommend:

The Head of Healthcare and the Mental Health Team Manager should ensure that:

- **mental health referrals are actioned and recorded, and assessments take place with appropriate urgency.**

- **ACCT procedures are not used to substitute urgent mental health assessments.**

Mr McQuoid's substance misuse care

87. Mr McQuoid had a history of substance misuse and was engaged with the substance misuse service at Risley. On 26 February, when his behaviour became erratic, staff noted that he might be under the influence of PS. The following day, Mr McQuoid told staff that he had indeed taken PS and could not remember anything about the previous day's events.

88. Despite these concerns, prison staff did not consider inviting a representative from the substance misuse service to the ACCT case reviews, or even to alert them to Mr McQuoid's possible illicit drug use. This was a missed opportunity to ensure Mr McQuoid received appropriate support. We recommend:

The Governor and the Head of Healthcare should ensure that:

- **any information suggesting a prisoner has or is at risk of substance misuse is shared with the substance misuse service, and**
- **the substance misuse service are invited to ACCT reviews as appropriate.**

Joint care planning

89. The clinical reviewer identified little joined up working between the mental health team and the substance misuse service at Risley in respect of Mr McQuoid's care.

90. In our previous investigation into the death of a prisoner at Risley in May 2021, we recommended that the mental health and substance misuse teams took a more collaborative approach to prisoners' care, treatment, and support. The prison accepted our recommendation and said:

'… The Dual Diagnosis meeting would be reviewed. To ensure a collaborative approach, there would be fortnightly meetings between departments. Identifying those prisoners who appear on both teams with both departments highlighting their case worker for each prisoner, and holding a joint meeting to identify the correct pathway or arrange joint care planning if required ...'

91. This action was due to be completed in April 2021, which was after Mr McQuoid's death. We therefore do not repeat the recommendation but would expect the Governor to reassure herself that appropriate action has been taken to implement this fully.

Emergency response

92. Prison Service Instruction (PSI) 03/2013 requires Governors to have a medical emergency response code protocol, which instructs staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance immediately as soon as an emergency code is called.

93. When the officer found Mr McQuoid hanging in his cell, he immediately used his radio and asked for assistance from other staff. Although staff responded quickly, the officer did not radio a code blue as he should have done. As a result, an ambulance was not called immediately. Although it is unlikely the delay of four minutes affected the outcome for Mr McQuoid, failure to call a medical emergency code could be critical in other cases. We make the following recommendation:

The Governor should ensure that all staff use the medical emergency codes as set out in PSI 03/2013.

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