Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Higgins, a prisoner at HMP Rochester, on 7 February 2024

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 Sean Higgins was found hanged in his cell at HMP Rochester on 7 February 2024. He was 45 years old. I offer my condolences to Mr Higgins' family and friends.

Staff monitored Mr Higgins using suicide and self-harm prevention procedures (known as ACCT) from 6 to 30 January 2024. Throughout this time, he isolated himself, experienced hallucinations and reported suicidal ideation. The procedures were poorly managed. Despite his apparent symptoms of deteriorating mental health, there was very little input from the mental health team. Support actions were ineffective and did not address some significant issues. The procedures were closed prematurely, failing to consider evidence of heightened risk of suicide and self-harm.

Prison managers have recognised deficiencies in the management of Mr Higgins' ACCT procedures. It is important that the Governor continues to review the operation of ACCT procedures, to ensure that they provide effective, meaningful support to prisoners who are at risk of suicide.

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 **October 2024**

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Summary

Events

1. In June 2018, Mr Sean Higgins was remanded in custody for attempted grievous bodily harm. He later received a sentence of 12 years in prison. Mr Higgins was diagnosed with paranoid schizophrenia and, in his first year in prison, was monitored under suicide and self-harm prevention procedures (known as ACCT) on three occasions.

2. In January 2021, Mr Higgins was transferred to HMP Rochester. He was monitored under ACCT procedures four times. Mr Higgins often self-isolated and had spent time in the segregation unit due to beliefs that other prisoners were threatening him.

3. On 29 December 2023, Mr Higgins began to isolate, as he said that he was hearing voices and believed that other prisoners were threatening him. He continued to isolate for the remainder of his life.

4. On 6 January 2024, prison staff began ACCT monitoring when Mr Higgins tied a ligature around the tap in his cell. On 26 January, Mr Higgins told staff that he felt like barricading his cell and hanging himself due to the fear of other prisoners. On 30 January, staff closed the ACCT procedures.

5. On 7 February, staff did not complete morning routine checks. At around 11.40am, officers found Mr Higgins hanged in his cell. At 12.07pm, paramedics confirmed that Mr Higgins had died.

Findings

6. Mr Higgins' ACCT procedures were poorly managed. There was no oversight by a named case co-ordinator and, despite his symptoms and apparent paranoia, a lack of input from the mental health team. Support actions did not sufficiently identify or address Mr Higgins' key issues. The ACCT procedures were closed when these issues were unresolved and when there was clear evidence that his risk of suicide and self-harm was raised.

7. Work to investigate and manage Mr Higgins' isolation and the threats he said he received was generic and not tailored to his issues and risk factors.

8. The clinical reviewer found that Mr Higgins' clinical care was not of the required standard and therefore not equivalent to that which would have been received in the wider community. Mr Higgins' poor compliance with his anti-psychotic and anti-anxiety medication was not reviewed and he was not supported to take his medication when isolating.

9. Staff falsified records when they recorded that they had carried out required checks on the morning of 7 February.

Recommendations

- The Governor should review the quality and compliance with policy of ACCT management in the previous 12 months, identify any improvements required, and devise a plan to deliver those improvements.

- The Governor should ensure that the ongoing review of the local Self-Isolation Strategy includes that isolating prisoners are properly supported, and that staff are trained in supporting prisoners towards ending self-isolation.

- The Governor should review the operation of CSIPs to ensure that staff are trained in setting meaningful support actions, there are consistent CSIP/ACCT case managers and prisoners' concerns about their safety are properly investigated and recorded.

- The Governor and Head of Healthcare should ensure that prison staff know when and how to refer prisoners to the mental health team, including for prisoners experiencing auditory hallucinations and being managed under ACCT procedures.

- The Governor and Head of Healthcare should ensure that prisoners who are not taking or collecting their medication are identified and reviewed, and that prisoners choosing to isolate are able to safely collect and take their medication.

- The Governor should review staff compliance with local roll check procedures and identify any improvements to practice required.

The Investigation Process

10. HMPPS notified us of Mr Higgins' death on 7 February 2024.

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

12. The investigator visited Rochester on 13 February 2024. She obtained copies of relevant extracts from Mr Higgins' prison and medical records, Rochester's safety and self-isolator policies, and staff statements.

13. The investigator interviewed one prisoner at Rochester on 13 February. She and an assistant ombudsman interviewed eight staff members on 20 and 26 March.

14. NHS England commissioned a clinical reviewer to review Mr Higgins' clinical care at the prison. She conducted five joint interviews with the investigator on 27 March and 8 April.

15. We informed HM Coroner for Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's office contacted Mr Higgins' brother to explain the investigation and to ask if he had any matters, he wanted us to consider. Mr Higgins' brother said that Mr Higgins did not receive his medication and that his mother had contacted the prison twice (before Christmas 2023) regarding this. Mr Higgins' family provided copies of the correspondence Mr Higgins' mother had sent to the prison in 2022 and 2023 which were acknowledged by the Governor and Head of Safety. HMP Rochester responded to Mr Higgins' mother on both occasions, providing reassurance that Mr Higgins was being supported by staff. His brother also asked why additional therapy that Mr Higgins had said he wanted was not available.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

18. Mr Higgins' family received a copy of the draft report. The solicitor representing Mr Higgins' family wrote to us expressing further information regarding the family correspondence referred to. The report has been amended accordingly and we have provided further clarification by way of separate correspondence to the solicitor.

Background Information

HMP Rochester

19. HMP Rochester is a category C resettlement prison holding adult and young male prisoners across seven residential units. Healthcare services for prisoners are provided by the Oxleas NHS Foundation Trust healthcare team, with an in-reach service for mental health wellbeing.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Rochester was in October 2021 and findings were outlined in a report published in February 2022. Inspectors reported that the daily regime for prisoners being managed under ACCT procedures did not adequately support well-being, and that only 22% of prisoners who had been on an ACCT said they felt cared for. ACCT documentation was generally completed to a reasonable standard. Inspectors also found that there was no evidence of key workers supporting prisoners on an ACCT.

21. An independent review of progress was undertaken in September 2022, which found that most prisoners still did not have any reliable, regular contact with a key worker to help them address any personal well-being issues and support their progression.

Independent Monitoring Board

22. 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 2024, the IMB reported that incidents of self-harm had increased (especially from December 2023), with many incidents related to hopelessness or debt. The number of prisoners monitored under ACCT arrangements was unchanged. The IMB noted that swift action by prison staff had prevented many attempts by prisoners to take their lives.

23. The IMB also reported that levels of violence had increased, much of it gang related, and that drug-related debt and bullying were significant elements of life at Rochester. The IMB noted that relatively few prisoners chose to isolate themselves.

24. In their report, ‘Segregation of men with mental health needs, a thematic monitoring report’ published in January 2024, the IMB found that prisoners with mental health needs isolated themselves on standard prison wings. Many IMBs were concerned that these prisoners were living in segregated conditions without the protection of the segregation rules and the level of monitoring that would be offered in a segregation unit.

Previous deaths at HMP Rochester

25. Mr Higgins was the fourth prisoner to die at Rochester since February 2021, and the second man to take his own life in that time. To the end of July 2024, there have not been any further deaths at the prison.

26. In our investigation into the self-inflicted death of a prisoner at Rochester in 2022, we recommended that the Governor should ensure that any concerns raised by a prisoner about their safety are properly investigated and recorded appropriately. In response, the prison said that all prisoners who raise a concern about their safety will be referred to challenge, support and intervention plan (CSIP) management.

Assessment, Care in Custody and Teamwork

27. 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 initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

28. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the actions of the support actions 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 the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody).

Key Events

Background

29. On 4 June 2018, Mr Sean Higgins was remanded in custody to HMP Elmley, charged with attempted grievous bodily harm. Over the following year, staff monitored him under ACCT procedures on three occasions. (These were the only times on which Mr Higgins was monitored under ACCT procedures before his transfer to HMP Rochester.) Mr Higgins had a history of substance misuse and was diagnosed with paranoid schizophrenia. On 31 May 2019, Mr Higgins received an extended sentence of 12 years.

30. In January 2021, Mr Higgins was transferred to Rochester. During this time, he received support from the Mental Health In-Reach Team (MHIRT). From September 2022, he was engaged with a psychologist. Mr Higgins was prescribed mirtazapine (an antidepressant), methadone (an opiate substitute), melatonin (to treat insomnia) and olanzapine (an anti-psychotic medication).

31. Mr Higgins often self-isolated and had spent time in the segregation unit due to beliefs that other prisoners were threatening him. He was monitored under ACCT procedures four times, when Mr Higgins said that he had heard voices telling him to harm himself.

32. In November 2023, Mr Higgins did not collect his medication because he said he was in danger from other prisoners. Staff attempted to make alternative arrangements for him to collect his medication, however he declined.

33. On 9 November, Mr Higgins was moved to the segregation unit for his own safety as he had reported receiving threats from other prisoners. He was referred to the Safety Intervention Meetings (SIM, a multidisciplinary meeting of different functions and senior managers to discuss and recommend actions to reduce risk for more complex prisoners). Prison records show that Mr Higgins had reported these issues sporadically since arriving at Rochester.

34. On 14 November, the psychologist discharged Mr Higgins from her care and summarised in her discharge letter that due to Mr Higgins spending significant periods of time in segregation or self-isolation, few psychology sessions were conducted. She noted that Mr Higgins had completed workbooks for dialectical behavioural therapy (DBT) during his isolation periods and that she had facilitated appointments at his door. She praised Mr Higgins for the positive changes he had made in his ways of thinking and coping with mood changes.

35. Later that day, a mental health nurse assessed Mr Higgins and reported that he had felt the effects of withdrawal since stopping methadone (following his non-attendance at the medication hatch) and that he had been hallucinating and hearing voices.

36. During his month in the segregation unit, Mr Higgins reported experiencing hallucinations. The mental health in-reach team assessed him and booked an appointment with a psychiatrist, which Mr Higgins did not attend (the reason for which was not recorded). There were no further attempts to reschedule this

appointment and as a result, Mr Higgins was not on the active MHIRT caseload. Towards the end of his segregation, Mr Higgins stopped reporting hallucinations, although a mental health nurse noted symptoms of low mood.

37. On 13 December, Mr Higgins returned to a cell on a standard residential wing. On the same day, staff completed a Challenge, Support and Intervention Plan (CSIP, a Prison Service violence reduction tool used to identify and manage prisoners at raised risk of harming others and to protect potential victims of violence) referral, after Mr Higgins wrote a note specifying names of prisoners from whom he said he was under threat due to debts.

38. On 15 December, prison staff returned Mr Higgins to the segregation unit because he had assaulted a staff member. He began to isolate and refused all activities and refused to attend a healthcare appointment on 18 December. (The assault was referred to the police, who investigated but did not charge Mr Higgins.)

39. On 23 December, Mr Higgins moved to E Wing, a standard residential unit.

40. On 27 December, an unnamed custodial manager (CM) conducted a CSIP interview with Mr Higgins following the note he had given to staff on 15 December. The CM decided to close CSIP monitoring, as Mr Higgins had engaged with the regime since moving to E Wing, and because there had been no issues with the one prisoner he had previously raised concerns about on that wing.

41. On 29 December, a Supervising Officer (SO) completed a new CSIP referral and investigation form because Mr Higgins had begun to isolate again and said that he believed that he was under threat on E Wing. She noted that staff should create goals that would aid in reducing Mr Higgins' self-isolation time and work with Mr Higgins to create a safe environment.

42. On 1 January 2024, Mr Higgins told staff that he was isolating because he was hearing voices and his head "wasn't in the right place". He believed that he was being called a "nonce" (prison slang for a sex offender). Staff recorded that a CSIP interview with Mr Higgins took place and that he was now under full CSIP monitoring during his self-isolation.

43. There is no record of staff conducting Mr Higgins' scheduled medication review on 2 January. (At the time, Mr Higgins was not collecting his medication.)

44. On 5 January, healthcare staff undertook a review of Mr Higgins' mental health care plan (for which he was not seen in person). He later declined to attend an MHIRT appointment.

6 – 30 January 2024

45. On 6 January, staff discovered that Mr Higgins had created a ligature and tied this around his cold water tap. He told staff that he was in a "bad way" and was hearing voices that were telling him to kill himself. Staff began ACCT monitoring. Mr Higgins did not attend an MHIRT appointment in the afternoon and told staff in the evening that he was still hearing voices.

46. On 7 January, several ACCT management actions were undertaken:

- A SO completed an immediate action plan (IAP). Mr Higgins reported that he felt safest when he was isolating and that he was anxious at having his door opened, so would not meet with staff. He also said that he needed to be referred to the MHIRT. She reported in interview that she was unsure why this IAP was completed the day after ACCT monitoring began (rather than within one hour of the concern form being raised, as national instructions require).

- An officer conducted Mr Higgins ACCT assessment. He stated in interview that he was given short notice and had no time to review key information to support this assessment. When discussing immediate actions with Mr Higgins, the officer highlighted self-isolation, MHIRT engagement and chaplaincy within the ACCT assessment. These actions were not recorded on the Sources of Support section of Mr Higgins' Care Plan. (The ACCT assessment took place over 24 hours after Mr Higgins' ACCT was opened, contrary to national instructions.)

- Mr Higgins' first case review was coordinated by the SO with the officer. Initially Mr Higgins was reluctant to engage, and the review was conducted in his cell. He reported that isolation helped him feel safe and his reason for isolating was due to a breakup with his girlfriend six months ago. Healthcare attendance is mandatory at the first case review but there was no representative as the mental health team at Rochester are not contracted to work on a Sunday (and no one from any other healthcare disciplines was invited).

- A support action was set for Mr Higgins to engage with the MHIRT, and the second case review was set for the following day (8 January) to enable MHIRT to attend. In interview, both the SO and officer were unable to clarify what steps were taken to refer Mr Higgins to the MHIRT or to request their attendance at the second review. The SO reported that this is the responsibility of the ACCT case coordinator, and that she was only covering the review due to it being a weekend. (There was no case co-ordinator named on the ACCT document.)

- The SO set ACCT observations at a minimum of one every half an hour until the second review.

47. On 8 January, the scheduled second ACCT review did not take place. Mr Higgins told staff that he was still hearing voices and they assured him that a full review, including MHIRT, would happen the next day. The police notified the prison that they would not be charging Mr Higgins' with the staff assault (before Christmas) and that this could be dealt with by way of prison adjudication.

48. On 9 January, SO A chaired the second case review. SO B attended and a nurse provided a verbal contribution prior to the review, detailing that Mr Higgins' current paranoid beliefs had occurred on every wing at Rochester. SO A recorded that Mr Higgins said that he had stopped taking some of his medication because he did not think that it worked. No support actions were set. In interview, she reported that she remembered making a referral to the MHIRT however there is no evidence that she did. Mr Higgins' observations were reduced to a minimum of one per hour.

49. A Custodial Manager (CM) and a SO A discussed Mr Higgins at a CSIP review. SO B spoke with Mr Higgins and noted his concerns regarding feeling under threat from other prisoners in the CSIP document. SO B also noted that staff had been monitoring prisoners and that there was no evidence to suggest any were gathering at his door or behaving in a way to arouse suspicion. There was no evidence of goals being created through the CSIP plan to help mitigate Mr Higgins' self-isolation.

50. On the same day, Mr Higgins' prescription was stopped, seemingly because he had stopped collecting his medication. The mental health team leader said that Mr Higgins not taking his medication was not escalated to her. She told us that the mental health team rely on colleagues highlighting and referring issues such as medication refusal or deteriorating mental health to them when a patient is not on their current caseload.

51. On 11 January, Mr Higgins told an officer that he was still hallucinating and hearing voices. He said that he should be taking his medication and that he had not spoken to his family because they could tell by the tone of his voice if he was feeling down. The officer recorded this on his ACCT document.

52. On 16 January, the officer recorded that Mr Higgins said he wanted to see the MHIRT. No one completed a referral.

53. SO A chaired an ACCT case review, which was attended by representatives from the substance misuse and the safer custody teams. Mr Higgins did not want to leave his cell and stated that he wished to move to A Wing (the incentivised substance free living (ISFL) unit). The SO updated the support plan to include Mr Smith's wish to move to the ISFL unit. No additional support actions were set.

54. On 17 January, SO A told Mr Higgins that he did not fit the criteria for the ISFL unit and encouraged him to participate in the regime in order to be considered for this in the future. He agreed that he would come out of his cell when other isolating prisoners did. However, following their conversation, Mr Higgins continued to isolate.

55. On 18 January, Mr Higgins told staff that he wanted his sentence to end. He told an officer that he was doing a bit better, but that the MHIRT did not attend his last ACCT review.

56. On 20 January, Mr Higgins refused to attend an adjudication hearing relating to the staff assault (that occurred before Christmas), which he said was due to hearing voices and not being "in the right frame of mind". He pleaded guilty to both charges. A subsequent hearing was not set, and Mr Higgins' adjudication was outstanding when he died.

57. Over the following days, Mr Higgins continued to isolate and reported hearing voices.

58. On 23 January, Mr Higgins told an officer that he had received a video-call that morning from his family and that he "wasn't in the right head space".

59. On the same day, a SO chaired the fourth ACCT case review, with SO B also present. Mr Higgins said that he was still hearing voices and refused to engage with

the review. No one from the MHIRT was present and they did not provide any other input.

60. A CM discussed Mr Higgins at a CSIP review. She noted that he continued to isolate and that a transfer request was being explored as Mr Higgins could not be located on another wing at Rochester.

61. On 24 January, a SO chaired the fifth ACCT case review, with SO B also in attendance. Mr Higgins did not leave his cell. He reported that he was still hearing voices and that the MHIRT had done "everything they could". The SO told us that she believed Mr Higgins was waiting for a psychologist appointment, but she was unsure whether this had been scheduled and that she did not take any action to confirm or progress any MHIRT engagement. She updated the support plan to include the following actions: for Mr Higgins to accept the regime and report any new problems, for him to request books from the library, and for wing managers to look into a move to another location. She reduced the level of observations to every three hours and meaningful conversations to one in the afternoon.

62. On 25 January, the ongoing record showed no evidence of staff having any meaningful conversations with Mr Higgins.

63. On 26 January, Mr Higgins refused to see the chaplain and declined his evening meal. He spoke with an officer and told him that he "couldn't take it anymore", and that he was being accused by other prisoners of being a "nonce", "snitch" and "racist". He told the officer that he felt like barricading his cell and hanging himself. The officer reflected in interview that Mr Higgins calmed down but that he was very concerned about Mr Higgins' mental health. He recorded the conversation in the ACCT document.

64. On 27 January, Mr Higgins told the officer that he still felt the same as the night before, but that he no longer wished to barricade his cell and hang himself. The officer emailed a CM, SO A, SO B and the Safer Custody team, detailing this conversation and requesting assistance to support Mr Higgins.

65. On 29 January, the officer observed that Mr Higgins was visibly shaking and sweating. Mr Higgins told him that he could not "get out of his head".

66. On 30 January, Mr Higgins was discussed at a SIM, where staff noted that more information was needed from the wing and MHIRT. The Head of Safety told us that they were waiting for more detailed information about Mr Higgins' ACCT and that previously an update had been requested from wing staff, but information had not been provided.

67. Later that morning, Mr Higgins told staff that he was not in a good way and was still hearing voices.

68. Later that day, a CM chaired the sixth ACCT case review, which was attended by Mr Higgins and SO A. The review was conducted through Mr Higgins' cell door as he refused to leave his cell. The CM's case review notes detail that Mr Higgins was in a low mood and was convinced that other prisoners had been shouting at him and banging on the pipes at night, which was causing him "mental torture". He

reported no current thoughts of suicide or self-harm and stated that he wished to continue to isolate. Staff closed Mr Higgins' ACCT monitoring.

69. SO A stated in interview that the decision to end Mr Higgins' ACCT monitoring was made on the basis that he had not expressed suicidal ideation. She confirmed that she had reviewed Mr Higgins' ACCT document prior to the review. She said that she did not know about the concerns raised by the officer in his email or in the ACCT ongoing record. We were unable to interview the CM due to her extended absence from work.

31 January – 6 February

70. Mr Higgins continued to isolate during this period. Staff completed his seven-day post-closure monitoring form and reported that he continued to isolate but accepted his meals. They variously noted that Mr Higgins was "ok", "happy" or "quiet". There was no evidence on any of the days of meaningful conversations or staff encouraging Mr Higgins to leave his cell.

71. On 4 February, CCTV of E Wing shows Mr Higgins leave his cell to empty his bin. This is the last time he was seen outside of his cell.

72. On 6 February, SO B spoke with Mr Higgins, who again reported that prisoners had been calling him a "nonce" and had been banging on the walls either side of his cell. The SO asked Mr Higgins if he would like to move to a therapeutic prison and he said he would be happy to do so. A review was set for one weeks' time to enable staff to contact the relevant prisons. In interview, he clarified that he was unsure if there were already plans to move Mr Higgins, but this was something he was going to look into.

73. At 5.12pm, staff unlocked Mr Higgins' cell and collected his dinner plate. Around an hour later, an officer spoke to Mr Higgins through his observation panel for less than a minute. The officer's entry on the ACCT post-closure monitoring form details that Mr Higgins was watching television, had had his evening meal and had no issues or concerns.

74. CCTV shows that Mr Higgins had no further interactions with staff members that day.

Events of 7 February

75. Shortly after midnight, CCTV shows Mr Higgins' switched his cell light on for around seven minutes.

76. An officer signed that she had completed an early morning routine roll check (which should take place between 5.00am and 6.00am and is primarily a security measure to check prisoners are in their cells), but CCTV shows that she did not do so. Another officer was due to complete a roll check at 7.30am, but CCTV footage shows that this did not take place. The Governor informed the PPO that a local investigation into these officers is ongoing.

77. At 8.00am, an officer attended Mr Higgins' spur to unlock prisoners who had appointments. She stated in interview that her role was to unlock prisoners for work and since Mr Higgins' was self-isolating, she did not check on him.

78. At approximately 11.40am, Officer A went to serve Mr Higgins his lunch. He did not respond when she knocked at his cell door and called out to him. She found that she could not open Mr Higgins' door. She looked through the observation panel, but the cell was dark because the curtain was drawn. She could see grey material on the floor which she thought was Mr Higgins' legs. She was unsure whether this was a code blue (to indicate a medical emergency when someone is not breathing) or a barricade incident and pressed the general alarm at 11.41am.

79. Officer A turned on her body worn video camera (BWVC) and attempted to open the door. She waved Officer B over to assist. At 11.43am, they were able to open the cell door and found Mr Higgins hanging from a ligature, which he had tied around the sink tap. Mr Higgins' legs were outstretched blocking the doorway. Officer A radioed a medical emergency code blue. Officer B cut the ligature. Another prisoner was outside the cell and offered his assistance in carrying out CPR. Officer B let him in, and he commenced cardiopulmonary resuscitation (CPR). (The prisoner explained in his interview that he had recently completed CPR training in the community.)

80. At 11.44am, the control room operator called an ambulance. The recording of the 999 call and ambulance records show that there was some confusion regarding the reason for the call as a fight had broken out on the same wing at a similar time. Nonetheless, an ambulance was dispatched to the prison and arrived promptly.

81. Officer B attempted to clear Mr Higgins' airway. However, he realised that his tongue was swollen, and his jaw was locked and purple. The prisoner continued with CPR and Officer A gave Officer B her face shield to commence rescue breaths in between chest compressions. Shortly after, another officer arrived and took over chest compressions and another officer arrived with a defibrillator, which was attached to Mr Higgins' chest.

82. At 11.46am, healthcare staff arrived and took over the resuscitation. A nurse requested that officers move Mr Higgins' outside of the cell to enable more room for the response.

83. At 12.00pm, paramedics arrived and, after assessing Mr Higgins, identified that rigor mortis had set in. They concluded that there were no signs of life and resuscitation efforts ceased. At 12.07pm, the paramedics confirmed that Mr Higgins had died.

84. Mr Higgins left a note in his cell, in which he wrote that he could not carry on and that his mental health symptoms had become too much for him to manage.

Contact with Mr Higgins' family

85. A senior manager informed us that at the time of Mr Higgins' death, there were no family liaison officers (FLOs) available at Rochester because they were either involved in the emergency response or waiting to be trained. The Head of Safety requested regional support to provide a FLO, but none was immediately available.

To avoid further delay, Rochester asked the police to inform Mr Higgins' family of his death, which they did later on 7 February.

86. On 8 February, a FLO from HMP Elmley visited Mr Higgins' family. Rochester contributed towards Mr Higgins' funeral costs in line with national guidance.

Support for prisoners and staff

87. After Mr Higgins' death, a senior manager and the Head of Healthcare 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.

88. The prison posted notices informing other prisoners of Mr Higgins' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Higgins' death.

89. The prisoner told us that he was supported by staff from a variety of disciplines. He said that he had a good relationship with wing staff and was able to talk to them about Mr Higgins' death.

Post-mortem report

90. The Coroner concluded that the cause of Mr Higgins death was hanging. Toxicology results did not identify any illicit substances.

Findings

Managing the risk of suicide and self-harm

91. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* contains requirements for staff using Assessment, Care in Custody and Teamwork (ACCT) procedures. Staff are required to use ACCT when they identify that a prisoner is at risk of suicide and self-harm, based on identified risk factors and triggers. The PSI says that ACCT case reviews should be multidisciplinary where possible, that a support plan should be completed at the first review, and that it must reflect the prisoner's needs, level of risk and the triggers of their distress. Support actions must be tailored to meet the individual needs of the prisoner, be aimed at reducing the prisoner's risk to themselves and be time-bound.

92. Mr Higgins was monitored under ACCT procedures between 6–30 January 2024. Staff appropriately started the procedures when Mr Higgins' was discovered with a ligature in his cell. However, we are concerned that the procedures were very poorly managed and did little to support Mr Higgins.

Starting ACCT monitoring

93. PSI 64/2011 requires that when ACCT procedures are started, the immediate action plan (IAP) should be completed within one hour of the concern form being raised, and the ACCT assessment should be conducted within 24 hours. Both Mr Higgins' IAP and ACCT assessment were completed more than 24 hours after the procedures were started, outside the timeline set out in policy. A SO told us that when ACCT procedures are started, the duty manager (orderly officer) contacts a wing manager to ask them to complete the IAP. She said that she could not recollect why Mr Higgins' IAP (and therefore his assessment) were completed late.

ACCT management and case review attendance

94. PSI 64/2011 instructs that a case co-ordinator must be appointed at the first case review, who is responsible for arranging and chairing case reviews. It states that that healthcare staff must always be invited to attend, or provide a written contribution to, the first case review and any subsequent case reviews where they are relevant to supporting the prisoner.

95. Mr Higgins' ACCT procedures were not managed by a single case co-ordinator to ensure consistency. In total, Mr Higgins' six ACCT reviews were chaired by six separate case co-ordinators.

96. No one from the healthcare team attended Mr Higgins' first case review. We appreciate that the mental health team at Rochester are not contracted to work at the weekend, but there is no evidence that staff from other healthcare disciplines were invited or considered. This is important as staff in other healthcare disciplines can advise, signpost or refer as required for additional services or support. As well as this, no one referred Mr Higgins to the mental health team despite both his request to speak to them at the first case review and his behaviour evidencing a potential need for referral and assessment. Mr Higgins was told that a member of

the mental health team would attend his second case review, but this did not happen.

97. Despite there being concerns around Mr Higgins' mental health (including auditory hallucinations) and his refusal to take medication, healthcare staff did not attend any of the case reviews and there was no subsequent referral to the mental health team. On one occasion, the MHIRT provided a verbal contribution.

98. General practice at Rochester is for healthcare staff to only attend ACCT reviews when that individual is on their current caseload. In interview, the Head of Healthcare and the mental health team leader stated that they did not receive any communication from prison staff regarding Mr Higgins' condition nor any requests for healthcare staff to attend his ACCT reviews.

Support actions

99. PSI 64/2011 states that during case reviews, the case review team must set and review support actions to mitigate risk. ACCT user guidance says that support actions are one of the most important parts of the care plan. They must contain meaningful actions with clear outcomes and owners and must identify all immediate and longer-term risks and actions taken to mitigate them.

100. Support actions could have been set to address issues that affected Mr Higgins' risk, including his isolation and medication concerns. Despite a support action being set for Mr Higgins' to engage with the MHIRT, there is no evidence to suggest that staff made any attempt to refer or help him to engage with the MHIRT. The mental health team leader reported that the MHIRT received no information regarding Mr Higgins throughout his ACCT. She stated that typically support actions regarding engagement with the MHIRT are only passed on when the MHIRT attend reviews.

101. Other support actions on Mr Higgins' ACCT were not meaningful and supportive. There is little evidence that staff considered the effectiveness of these support actions at case reviews and whether anything else could be done to better support Mr Higgins.

ACCT Closure

102. PSI 64/2011 states that an ACCT can be closed when the risk of harm has been reduced to a level where this is no longer considered raised, and all support actions have been completed with their intended outcome achieved. It notes that some risks may be long term and may not be fully resolved when the decision is made to close the ACCT, however the ACCT can still be closed if these have been sufficiently reduced and support has been established to help the prisoner manage these.

103. Mr Higgins' ACCT monitoring was ended prematurely. There is no evidence that Mr Higgins' risk of self-harm had reduced or that his support actions had been completed. Mr Higgins continued to isolate from the regime, had few interactions with staff or other prisoners and had no involvement with the MHIRT despite continuing to say that he heard voices, including just a few hours before the ACCT procedures were closed.

104. Mr Higgins had also expressed suicidal intent a few days before staff ended his ACCT monitoring. An officer documented this conversation on his ACCT document and prison record, and emailed a CM, SO A, SO B and the Safer Custody team. SO A told us that at the final ACCT review she reviewed Mr Higgins' ACCT document but that she did not have knowledge of his recent suicidal ideation. She stated that had she been made aware of this, it would have changed the decision to close Mr Higgins ACCT monitoring that day.

105. We are satisfied that there was sufficient information provided on Mr Higgins' ACCT record, prison record and email communication for the CM and SO A to have been aware of these concerns and of Mr Higgins' ongoing issues. Closing Mr Higgins' ACCT at this time was not in line with PSI 64/2011.

106. Following Mr Higgins' death, the Governor conducted a disciplinary investigation into the CM and SO A's closure of Mr Higgins' ACCT procedures. We have been informed that the disciplinary investigation for the CM Meehan has concluded and resulted in a written warning. The disciplinary investigation for SO A is ongoing.

Early Learning

107. Since Mr Higgins' death, the Head of Safety and the Head of Healthcare have undertaken work to improve healthcare attendance at ACCT reviews by introducing an ACCT booking system. The Head of Safety told us that he has introduced a singular case manager system (from 1 April) that ensures a consistent case co-ordinator throughout the entirety of an ACCT. The Head of Healthcare highlighted in the 72-hour review that self-isolators should have regular interactions with healthcare staff and, to facilitate this, self-isolators will now be discussed at local healthcare delivery meetings.

108. While we appreciate that the Head of Safety has recognised deficiencies in the management of ACCT procedures at Rochester and taken steps to improve the practice since Mr Higgins' death, we are concerned by the extent of the ACCT failures we identified. We make the following recommendation:

The Governor should review the quality and compliance with policy of ACCT management in the previous 12 months, identify any improvements required, and devise a plan to deliver those improvements.

CSIP and self-isolators

109. Rochester has a Self-Isolation Strategy, dated 2019, which states that CSIP should be used to work with isolating individuals towards an agreed set of actions, to aid them in progressing away from isolation. It says that these actions should be meaningful and tailored to the individual.

110. PSI 64/2011 requires that where both ACCT and CSIP monitoring is in place, there should be a single case manager. Rochester's Safety Strategy, dated 2023-2024, states that ACCT reviews and CSIP reviews will be completed by the same designated case manager, and this will be measured through the quality assurance process.

111. Mr Higgins had regularly reported that he was isolating due to fearing for his own safety. Staff reported in interview and in prison records that these were concerns Mr Higgins had expressed since arriving at Rochester in 2021. However, there is very little detail regarding the specific action taken by staff to monitor these concerns, despite Mr Higgins sometimes providing the names of prisoners from whom he said he was under threat.

112. While CSIP was used to manage Mr Higgins' isolation, this was not tailored towards his specific concerns, and included general actions such as "to engage with the regime". There is no evidence that staff considered exploring incremental goals to help Mr Higgins gradually adjust to the regime. There was also no designated joint CSIP/ACCT case manager.

113. The Head of Safety told us that Rochester's Self-Isolation Strategy is currently under review. He reported that he had recognised that CSIP practice at Rochester was inconsistent and key actions identified did not always happen. SO B reported in interview that there was little training regarding how to manage CSIPs. Despite the local policy referencing several sources of support for self-isolators, it does not appear that any of these were explored with Mr Higgins.

114. We make the following recommendations:

The Governor should ensure that the ongoing review of the local Self-Isolation Strategy includes that isolating prisoners are properly supported, and that staff are trained in supporting prisoners towards ending self-isolation.

The Governor should review the operation of CSIPs to ensure that staff are trained in setting meaningful support actions, there are consistent CSIP/ACCT case managers and prisoners' concerns about their safety are properly investigated and recorded.

Mental health care

115. Mr Higgins had complex needs and displayed symptoms of distress in the weeks leading up to his death. The clinical reviewer concluded that there was a lack of insight and awareness into Mr Higgins' risk factors of hallucinations and self-isolation. His poor compliance with medication was not acted upon and there were significant breakdowns in communication between prison staff and healthcare staff. Mr Higgins' medication was stopped without any review of the reasons why he had stopped collecting it or any consideration of how he might be supported to continue.

116. The clinical reviewer concluded that there were several omissions and missed opportunities to provide Mr Higgins with the support he needed and, as a result, the clinical care he received was not equivalent to that which he would have received in the wider community. We make the following recommendations:

The Governor and Head of Healthcare should ensure that prison staff know when and how to refer prisoners to the mental health team, including for prisoners experiencing auditory hallucinations and being managed under ACCT procedures.

The Governor and Head of Healthcare should ensure that prisoners who are not taking or collecting their medication are identified and reviewed, and that prisoners choosing to isolate are able to safely collect and take their medication.

Roll checks

117. On the morning that Mr Higgins died, two members of staff failed to complete roll checks. One staff member signed that they had completed their roll check, but CCTV shows that they did not do so.

118. The Governor informed us that a local investigation will be conducted into these events.

119. The Governor has also issued staff notices to remind staff of local policy and of the importance in ensuring roll checks are carried out adequately. Nevertheless, it is concerning that two separate staff members failed to complete roll checks and one staff member seemingly falsified records about this issue. The Governor will wish to ensure that this issue is not widespread and that these important checks are conducted properly in future.

The Governor should review staff compliance with local roll check procedures and identify any improvements to practice required.

Family liaison

120. PSI 64/2011 instructs that, wherever possible, the family liaison officer (FLO) and another member of staff must visit in person the next of kin to break the news of the death. It says that time is of the essence, to try to ensure that the family do not find about the death from another source.

121. There was no FLO available at Rochester when Mr Higgins died, and none at any of the other prisons in the region. Prison staff therefore asked the police to break the news to Mr Higgins' family.

122. Since Mr Higgins' death, a regional process for requesting FLO support has been established to prevent there being delays in appointing a FLO. Additional staff at Rochester have also been identified to complete FLO training.

Inquest

123. The inquest of Mr Higgins' death was opened on 16 February 2024 and concluded on 17 February 2025. The conclusion was that there were multiple failings in the management of Mr Higgins' mental health and that his death was due to suicide.

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