Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tyrone Richards, a prisoner at HMP Manchester, on 25 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 HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Tyrone Richards was found hanged in his cell at HMP Manchester, on 25 October 2022. He was 32 years old. I offer my condolences to Mr Richards' family and friends.

Mr Richards spent almost all of his adult life in prison. Staff had managed him under suicide and self-harm prevention procedures (known as ACCT) on several occasions, although not for three years before he died. While he had additional risk factors for suicide and self-harm, there was little to indicate that he was at heightened risk in the time immediately before his death.

Mr Richards was one of a record number of prisoners serving Imprisonment for Public Protection (IPP) to take their lives in 2022. It is important that the Governor, and other senior leaders in HMPPS, learn from his death and others that I highlighted in my recent Learning Lessons Bulletin about the self-inflicted deaths of IPP prisoners.

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 **June 2024**

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Summary

Events

1. In July 2009, Mr Tyrone Richards was charged with wounding with intent to do grievous bodily harm. He was given an Imprisonment for Public Protection (IPP) sentence in February 2010, with a minimum tariff of two years and 163 days.

2. In 2016 and 2018, Mr Richards was released from prison on licence after being granted parole but was recalled both times due to poor behaviour.

3. Mr Richards had a long history of using illicit substances but refused to engage with substance misuse services in prison. He had a history of self-harm and attempted suicide by ligature in 2019, while in prison.

4. On 8 July 2022, Mr Richards transferred to HMP Manchester from HMP Lindholme. Healthcare staff screened Mr Richards and found there was no indication of significant mental health issues. However, they referred him to 'OUTSPOKEN', a counselling service based in the prison. He died before he could receive his first session.

5. On 23 September, Mr Richards was assaulted by another prisoner, who was charged with an offence against prison discipline. Staff suspected that the assault might have been related to debt.

6. At around 8.15am on 25 October, a prison officer attended Mr Richards' wing to unlock prisoners for their education classes. Mr Richards said he did not want to attend because he had a headache.

7. At around 11.50am, two prisoners shouted to another prison officer on the landing that they could see, through a small gap in Mr Richards' cell door, that he had hanged himself. Officers quickly entered the cell, called a medical emergency 'code blue' and began cardiopulmonary resuscitation (CPR). Healthcare staff arrived shortly afterwards.

8. Paramedics arrived at the cell shortly after 12.00pm and took over CPR. At 12.38pm, they confirmed that Mr Richards had died.

Findings

9. Mr Richards had a history of self-harm and attempted suicide and had been managed under suicide and self-harm prevention procedures (known as ACCT) several times previously. While he also had other risk factors for suicide and self-harm, we are satisfied that there was little to indicate that he was at heightened risk in the time before his death.

10. Mr Richards was not prioritised for key work while at Manchester and did not therefore receive any meaningful key work sessions. Prisons serving IPP sentences have since been added to the priority group.

The Investigation Process

11. We were notified of Mr Richards' death on 25 October 2022. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Richards' prison and medical records.

13. The investigator interviewed 16 members of staff at HMP Manchester on 4 and 6 January 2023.

14. NHS England commissioned a clinical reviewer to review Mr Richards' clinical care at the prison. All interviews were conducted jointly with the clinical reviewer.

15. We informed HM Coroner for Manchester City 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 family liaison officer contacted Mr Richards' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Richards' mother said that she had received two different accounts of what happened; one was that staff had found Mr Richards and the other that prisoners had found him. She wanted to know which account was correct. Mr Richards' mother explained that her son had tried to hang himself on two previous occasions and that he had a history of depression. Consequently, she asked whether staff were checking on him regularly and, if not, whether they should have. We have addressed Mr Richards' mother's questions in our report and in the clinical review.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

18. Mr Richards' mother received a copy of the initial report. They did not make any comments.

Background Information

HMP Manchester

19. HMP Manchester is a high security prison designed for long-term prisoners. The prison holds up to 744 prisoners in nine residential units, a segregation unit, specialist intervention unit and a healthcare unit. During Mr Richards' time at Manchester, Greater Manchester Mental Health NHS Foundation Trust provided 24-hour nursing care.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Manchester was in September 2021. Inspectors reported that 25% of prisoners said they felt unsafe at the time of the inspection and those with mental health problems or other disabilities were significantly more negative than other prisoners. Although levels of violence were lower than at their previous inspection, the rate of serious assaults had increased.

21. Inspectors reported that the mental health team was responsive to demand, promptly assessing patients and prioritising support. They noted that a dual diagnosis pathway for patients with both mental health and substance misuse needs was being used effectively.

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 28 February 2022, the IMB reported that the prison had a steady decrease of self-harm in the early part of 2021, which mirrored trends shown across the prison estate throughout the COVID-19 pandemic.

23. The IMB reported that levels of self-harm rose sharply in September 2021, when COVID-19 restrictions were lifted, and has remained high ever since. To reduce this risk of self-harm, the Head of Residence aimed to ensure that all prisoners being monitored under suicide and self-harm prevention measures (ACCT) were allocated a key worker to provide them with that stability of support on top of the usual ACCT processes.

Previous deaths at HMP Manchester

24. Mr Richards was the 19th prisoner to die at Manchester since October 2019. Ten of the previous deaths were from natural causes, two were drug-related, four were self-inflicted and two were unclassified. Since Mr Richards' death, two further prisoners have taken their own lives at Manchester.

25. Our report into the death of a prisoner in May 2022 identified that the man did not receive key work in line with expectations, despite being a priority prisoner.

Imprisonment for Public Protection (IPP)

19. IPP sentences are indeterminate, which means that when the minimum tariff has expired, individuals are required to demonstrate to the Parole Board that their risk has reduced enough to be managed in the community. IPP sentences were introduced in 2005 and abolished in 2012, but the abolition did not apply retrospectively to those who had already received the sentence.

Assessment, Care in Custody and Teamwork (ACCT)

20. 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.

21. As part of the process, a support plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the support plan 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, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Key worker scheme

22. The key worker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversations which each of their allocated prisoners.

23. The key worker scheme was suspended across the estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, the Prison Service used an Exceptional Delivery Model until May 2022. This involved weekly conversations with prisoners identified as vulnerable.

24. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan, which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

Background

25. In July 2009, Mr Tyrone Richards was charged with wounding with intent to do grievous bodily harm. He was given an Imprisonment for Public Protection (IPP) sentence in February 2010, with a minimum tariff of two years and 163 days. Mr Richards had spent most of his teenage years and adult life in prison, from the age of 15. He was 32 years old when he died.

26. Mr Richards had a long history of using illicit substances in prison, including psychoactive substances (PS). Staff found him under the influence of drugs several times. They referred him to substance misuse services on several occasions, however he generally refused to engage with them.

27. Mr Richards also had a history of anxiety and depression, for which he was prescribed antidepressant medication. He had a history of self-harm and had previously attempted suicide by ligature. He received EMDR (eye movement desensitisation and reprocessing therapy) during 2017-18 at HMP Lancaster Farms to treat Post-Traumatic Stress Disorder (PTSD).

28. Prison staff put a challenge, support and intervention plan (CSIP) in place for Mr Richards on several occasions to manage the risk of violence he posed to other prisoners.

29. On 24 June 2016, Mr Richards was released from prison on licence after being granted parole. He was recalled to prison on 2 August 2017, due to poor behaviour.

30. On 7 November 2018, Mr Richards was released from prison on licence for the second time. He was recalled again on 15 August 2019, for poor behaviour. When he arrived in prison, Mr Richards threatened to harm himself, so staff began monitoring him under ACCT procedures. Staff closed the ACCT procedures on 6 September.

31. From 19 October to 1 November, staff monitored Mr Richards under ACCT procedures after he attempted suicide by ligature.

32. Between February and July 2022, Mr Richards was segregated at HMP Lindholme on four occasions for poor behaviour, including after he produced an improvised weapon during an adjudication hearing and attacked another prisoner with a sharpened toilet brush.

HMP Manchester

33. On 8 July 2022, due to his poor behaviour, Mr Richards was transferred to HMP Manchester (a Category B prison). The reception nurse completed Mr Richards' initial health screen. She recorded that there was no indication that Mr Richards was low in mood or thinking of self-harm. Mr Richards said that he had PTSD and knew he should see the mental health team but said that he did not usually engage with them. She did not record any information about Mr Richards' self-harm history.

34. After the reception health screening, a mental health nurse completed a mental health triage. She recorded that Mr Richards had overdosed on drugs in the past and had attempted suicide in 2019. She concluded that there were no signs Mr Richards was feeling in low mood or had thoughts or plans of self-harm, so did not make a referral to the mental health team. She referred him to 'OUTSPOKEN', a counselling service based in the prison.

35. The next day, a substance misuse worker visited Mr Richards in his cell to offer substance misuse advice and support. Mr Richards told him that he had no issues with drugs or alcohol and did not require any support. Mr Richards received no further input from substance misuse services.

36. On 14 July, a nurse completed Mr Richards' second health screening. She assessed Mr Richards' mental health and found there was no indication of significant issues.

37. On 25 July, a senior trauma counsellor from OUTSPOKEN completed Mr Richards' initial trauma assessment. At interview, she told us that Mr Richards engaged quite well and demonstrated future thinking. Mr Richards said that he had no thoughts of self-harm. She told him that the counselling service was heavily subscribed and that unless someone was deemed high risk, the wait was likely to be eight to nine months. Based on her initial assessment, she did not deem Mr Richards to be high risk. Mr Richards remained on the waiting list and received no further input from mental health services before his death.

38. On 1 September, Mr Richards received a letter confirming that his paper-based parole review had been unsuccessful, and that he would remain in prison until his next review in at least two years' time.

39. On 23 September, prison staff saw Mr Richards being punched by another prisoner on his wing. When they spoke to Mr Richards and the other prisoner, staff could not establish the reason for the assault, but suspected it may have been debt related. Mr Richards said he did not want to press charges and was happy for the incident to be dealt with via the adjudication process. (The prisoner who assaulted Mr Richards was later found guilty of an offence against prison discipline.) The Head of Safety told us that staff interviewed Mr Richards afterwards and that he said he was content to remain on the same wing as the other prisoner.

25 October

40. At around 8.15am, an officer attended Mr Richards' wing to unlock prisoners for their education classes. When he arrived at Mr Richards' cell, he found him lying in bed. Mr Richards said he did not want to attend his education class because he had a headache. In interview, the officer told us that he did not see any reason to challenge Mr Richards, so left him in his cell and continued his duties.

Emergency response

41. At around 11.50am, two prisoners shouted to an officer on the landing that, through a small gap in the cell door, they could see Mr Richards hanging. In interview, she

told us that Mr Richards had covered his cell observation panel with tissue. We do not know when Mr Richards first covered the observation panel.

42. The officer ran towards Mr Richards' cell, opened the door and saw that he had a ligature around his neck that was attached to the ceiling light. She climbed on to the top bunk bed and cut the ligature.

43. Another officer and a Supervising Officer (SO) entered the cell immediately after the first officer. At 11.51am, the SO radioed a medical emergency code blue (requesting assistance from staff and triggering a call to the ambulance service). An officer began cardiopulmonary resuscitation (CPR) with assistance from colleagues.

44. Around three minutes later, two nurses arrived at the cell in response to the code blue and set up the defibrillator. One nurse told us in interview that the defibrillator advised 'no shock to be given'.

45. Paramedics arrived at the cell shortly after 12.00pm and took over CPR. At 12.38pm, they confirmed that Mr Richards had died.

Contact with Mr Richards' family

46. Shortly after 5.00pm on 25 October, the prison family liaison officer (FLO) and an operational manager travelled to the home of Mr Richards' next of kin and broke the news of his death.

47. Manchester contributed to the costs of Mr Richards' funeral in line with Prison Service instructions.

Support for prisoners and staff

48. After Mr Richards' death, the duty operational manager 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.

49. The prison posted notices informing other prisoners of Mr Richards' 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 Richards' death.

50. The Head of Safety told us that there is no record of support offered to the two prisoners who found Mr Richards hanging. She said that usual procedures are for wing staff to support them immediately following the incident and to offer them the opportunity to speak to peers and Listeners (prisoners who have been trained by the Samaritans to offer support to those who request it).

Post-mortem report

51. The post-mortem report concluded that Mr Richards' cause of death was hanging.

52. Toxicology tests found that cannabis metabolites (substances produced by the body when processing cannabis) were present in Mr Richards' system.

Findings

Identifying the risk of suicide and self-harm

53. Prison Service Instruction (PSI) 64/2011 'Managing prisoner Safety in Custody' requires that staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm, so that they can take relevant action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Manchester should have identified Mr Richards as at risk and begun ACCT procedures to support him.

54. Mr Richards had some risk factors for suicide and self-harm. He was serving an IPP sentence and had spent most of his life in detention settings. He had recently had a parole application rejected. He had a documented history of poor mental health, suicide attempts and self-harm. Mr Richards had most recently attempted suicide by ligature in 2019 and prison staff had managed him under ACCT procedures several times, most recently in 2019. Around a month before he died, staff witnessed Mr Richards being assaulted by another prisoner, which they thought might have been related to debt.

55. While Mr Richards had these risk factors, we are satisfied that there was little to indicate to staff that he was at immediate risk of suicide at the time of his death. Mr Richards had not made a telephone call for around three weeks before he died and there was no indication that he had received bad news from family or friends.

56. In September 2023, we issued a Learning Lessons Bulletin that was prompted by the increase in self-inflicted deaths of IPP prisoners in 2022, which saw the highest number since the sentence was introduced. We highlighted that a prisoner's IPP status and parole hearings should be considered as potential risk factors for suicide and self-harm. We highlight later in this report that Mr Richards was not given the opportunity, through the key worker scheme, to discuss these risk factors.

Assault on 23 September

57. Manchester has a local violence reduction policy which states that they will identify and support those who are victims of violence. The policy states that all incidents should be reported correctly, with investigations and actions undertaken.

58. Prison staff interviewed Mr Richards after he was assaulted by another prisoner, who was charged with, and found guilty of, an offence against prison discipline through the adjudication process.

59. The Head of Safety told us that the Safety Team has since reviewed their post-violence procedures. Safer custody staff now complete welfare interviews after the initial interview by wing staff, to give prisoners a second opportunity to report concerns to a member of staff with whom they might feel more comfortable. We are satisfied that suitable action was taken against the perpetrator of violence against Mr Richards and that appropriate steps have since been taken to provide additional support for victims of violence.

Substance misuse

60. Post-mortem toxicology tests suggest that Mr Richards may have used cannabis in the lead up to his death, which may have affected his judgement and perception.

61. While Mr Richards had a history of using illicit drugs in prison, there is no record that he was ever suspected of using drugs at Manchester. We note that the substance misuse service tried several times to work with Mr Richards, however he consistently refused to engage with them. Substance misuse workers advised Mr Richards' of the risks of using illicit drugs and how to contact the team. The clinical reviewer did not identify any concerns regarding substance misuse services at Manchester.

Governor to note

Key work

62. One of the main aims of the Key Worker Scheme is to improve prisoner safety through meaningful contact with a consistent member of staff. The scheme usually requires 45 minutes of key work per prisoner per week, delivered by a named officer. During his time at Manchester, Mr Richards did not receive a full key work session and told a member of staff that he did not know who his key worker was. Our Learning Lessons Bulletin regarding IPP prisoners highlighted that they should be prioritised for key work and that the outcome of parole hearings and sentence progression should be considered and covered during key work sessions.

63. The Head of Safety told us that key work delivery has fluctuated since the pandemic but has never been above 30 per cent. She identified various reasons for this, including staff sickness, priority escorts for Category A prisoners and provision of staff on detached duty. She identified that Manchester has reviewed prisoner groups who are priorities for key work and that this now includes IPP prisoners. She told us that Manchester now allocates staff on restricted duties (such as those with health conditions that might prevent them from completing some wider duties) to key work to achieve better completion.

64. We appreciate that Mr Richards was not, at the time, a priority prisoner for key work and are pleased that Manchester has broadened its definition to include IPP prisoners. Key work is an important aspect of prison life, particularly for those who might be vulnerable but are not supported by other means such as ACCT procedures or through the mental health team. It is important that Manchester continues to strive to meet its obligations in the matter.

Head of Healthcare to note

65. Shortly after his arrival at Manchester, Mr Richards was assessed by OUTSPOKEN and added to their waiting list for counselling services, which was around eight to nine months. The clinical reviewer identified that the commissioning of this service at Manchester is a helpful addition to the services offered by the mental health team, and that waiting times are broadly equivalent to those in the community.

66. In the community those on the waiting list have access to additional sources of support (such as drop-in meetings) while they await counselling. Mr Richards received no additional support. The clinical reviewer found that interim mental health input while he was waiting for counselling could have been offered to Mr Richards, to assess his mood and potential risk.

Inquest

67. An Inquest into Mr Richards' death was opened on 27 October 2022 and concluded on 20 January 2025 found that Mr Richards' cause of death was hanging.

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