Investigation into the circumstances surrounding the death of a man at HMP High Down in May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

August 2008

This is a report into the circumstances of the death of the man at HMP High Down in May 2007. An officer who opened the man's cell to allow him to begin his duties as a hotplate worker discovered him hanging from the window bars. She summoned immediate assistance but, despite staff attempts at cardio pulmonary resuscitation and the attendance of paramedics, the man was pronounced dead shortly after 8.00am. He had been at High Down on remand for one month. An ACCT document had been closed six days earlier.

I offer my sincere sympathy and condolences to the man's family and friends for their loss.

The investigation was carried out on my behalf by one of my colleagues. A clinical review of the man's healthcare at HMP High Down was undertaken by a medical records reviewer on behalf of Surrey Primary Care Trust. I am grateful for her comprehensive review.

I would also like to thank the Governor of High Down and his staff for their co-operation and assistance with this investigation. Particular thanks go to the Head of Residence for his help throughout the investigation process as liaison officer.

Documents from the court and police had shown that the man had made a serious attempt to take his own life three days before he was remanded to prison. This was the latest instance of self-harm in a series of attempts stretching back several years. All were linked to depression. The man had the support of a loving family and many friends, but it seems his depression was at times overpowering.

The man appeared to have settled well at High Down and showed good progress. He left no note or indication to explain his actions. However, despite appearing cheerful, he had received a letter from his former partner ending their relationship.

I make eight recommendations, primarily covering healthcare processes, ACCT procedures and family liaison.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2008**

CONTENTS

SUMMARY

The man was born in January 1981 and died at HMP High Down in May 2007. He had been living at his parents' home when arrested. He was separated from his partner by whom he had a five year old son. He had suffered from depression for many years and had attempted to take his life several times.

In April 2007, the man set fire to his home in an attempt to commit suicide. When the emergency services arrived he stabbed himself in the stomach and cut his arm. He was arrested and taken to hospital where his wounds were treated. Three days later, he was remanded in custody at High Down.

The documents that accompanied the man from court highlighted his recent self-harm. The nurse who assessed the man in reception was sufficiently concerned to open an ACCT plan to give him the additional support he needed. He also admitted the man directly to the healthcare centre.

The man spent 10 days as an in-patient in the healthcare centre during which time staff observed him closely and offered him support. On 20 April, at an ACCT case review meeting which the man attended, it was decided he was well enough to be discharged from healthcare. Later that day, he moved to Houseblock (HB) 3 where he was put in a three-man cell.

The staff on HB3 continued to support the man through the ACCT as he gradually developed a more positive outlook. The man felt able to approach staff when he had problems. He told them his girlfriend was having a difficult pregnancy and later said that their relationship had ended. By 11 May, the man was much more positive. He had settled well into the team of prisoners working on the hotplate and told staff that being in prison had changed his life. The ACCT was closed and the man moved into a single cell later that day.

In May, an officer opened the man's cell at 7.25am. She saw him hanging from the window bars by a towel and raised the alarm. Officers and healthcare staff attempted resuscitation but rigor mortis had already set in. Paramedics who arrived just after 8.00am certified that the man had died.

Prison managers had much difficulty in tracing the man's parents. They eventually made contact but broke the news in a manner that greatly distressed the family. In spite of this difficult start, the family liaison officer appointed from a neighbouring prison provided good support.

THE INVESTIGATION PROCESS

1. The man died on Thursday in May 2007. My investigator visited the prison on the following Monday to open the investigation. She met the Governor and representatives of the Independent Monitoring Board and the Prison Officers' Association. She saw the man's cell in Houseblock (HB) 3 and walked around the unit. She was given copies of the man's prison records.

2. The investigator and clinical reviewer jointly interviewed staff and prisoners from both healthcare and HB3. The investigator also met with the Detective Inspector from Surrey Police, who conducted the police investigation into the man's death. He helpfully provided copies of statements made to his officers by staff and prisoners. He also supplied other documents, including letters received by the man that were found in his cell after his death.

3. One of my family liaison officers spoke to the man's mother to ask if the family had any concerns that they wished to be included in the investigation. They raised a number of issues, including whether a psychiatric assessment had been carried out, why the man was given a single cell in spite of recent self-harm, and what attempts prison staff made to obtain the man's parents' address before breaking the news of their son's death to them.

4. My family liaison officer also spoke to the man's former partner and nominated emergency contact, to ask whether she had any concerns. She too asked why the man was in a single cell and why prison staff did not inform her of his death.

HMP HIGH DOWN

5. HMP High Down opened in September 1992. It was initially a core local prison (able to take category A prisoners) but in 2003 it became a category B prison. At the time of the man's death it held approximately 750 prisoners. Since then, two new houseblocks have been opened.

6. Each Houseblock has three spurs (A, B and C) and each spur is broken down into three levels, 1 being the lower level, 2 the middle and 3 the upper level. There is a gate at the end of each spur.

7. High Down's regime includes education, catering, workshops, hairdressing, and painting and decorating courses. Accredited courses include enhanced thinking skills and core sex offender treatment programmes.

8. The healthcare centre has 23 in-patient beds, all in single cells, supported by 24 hour nursing cover. A range of primary care services is also available for prisoners. Four of the cells have gates rather than doors to allow staff to observe the patients in those cells more closely. There is a day area where the patients can watch television and relax. Twice a week, a member of the education staff attends the day centre and provides activities for the men.

9. The most recent inspection of High Down by Her Majesty's Chief Inspector of Prisons was an unannounced inspection in November 2004. The Chief Inspector of Prisons' report of her findings included the following:

   'Arrival into custody procedures were generally sound and well managed …'

   'On reception, staff engaged positively with prisoners. Although reception was essentially 'process' driven, due to the large numbers [of prisoners] involved … efforts [were made] to put prisoners at their ease and to explain procedures …'

   'There had been a significant improvement in the provision of healthcare services … since the last inspection. A combination of integration into the PCT and new management at governor and healthcare manager level had provided the catalyst to implement change …'

10. A Samaritans supported Listener scheme is in place for prisoners who are in distress or crisis and need to talk in confidence. (Listeners are prisoners who have volunteered for the role and have been trained by the Samaritans.)

KEY FINDINGS

11. On Wednesday 11 April 2007, the man was remanded into custody by a Magistrates' Court to await trial at Crown Court on 6 June. Whilst at court, the man was interviewed for almost an hour by a community psychiatric nurse employed by local Partnership NHS Trust. She completed a comprehensive assessment of the man's mental health and wrote a report as part of the Mentally Disordered Offender Assessment and Diversion Scheme.

12. The psychiatric nurse concluded that the man was not displaying any indications of a severe or enduring mental illness. However, he was showing signs of acute depression, for which he had been prescribed medication. She noted that the man's misuse of alcohol had caused the depression and led him to self-harm, and that it was a recurring pattern. Although she assessed him at medium risk of self-harm she concluded, "Should he be remanded today, the risk of Suicide would increase to HIGH and I would suggest that a Self-Harm Notification Document is opened when he is returned from court."

13. A prisoner escort record (PER) accompanies every prisoner as they move between police custody, the courts and the prison system. It is used to highlight any immediate concerns staff may have about the prisoner in their care, and to pass any relevant historical information to the next agency in line. The PER for the man highlighted that he had injuries and was at risk of self-harm and was on an almost constant watch. It also noted information from the Police National Computer that the man had attempted to harm himself when in police custody the previous year. Apart from interviews and his time in court, the man was observed at five minute intervals. When he returned to the cells after being remanded, an entry noted, "Not taken remand very well, maintaining five minute watch."

14. The care that the man received from the psychiatric nurse and the escort staff whilst at court was of a high standard and is to be commended.

Reception and healthcare

15. The local prison could not accommodate the man, so he was taken to HMP High Down, arriving there at 6.19pm. As with all prisoners, he was taken to reception where the senior officer checked the court papers. An officer then completed the personal summary sheet using information supplied by the man. (The officer did not sign the form or record his name and the man, who did sign it, put the date as 10 April rather than 11 April.) In the section, 'Distinctive marks' the officer listed six scars that the man had, including the fresh ones resulting from his self-harm three days earlier.

16. The man told the officer that he was of no fixed abode and gave no details for his next-of-kin. He gave his girlfriend's name and address as the person to be contacted in an emergency. The man did not name his parents as his next-of-kin because of incorrect information provided by the CPS at his court hearing. In opposing bail, the prosecution solicitor had said in open court that the man's parents had disowned him - which was not the case. However, his

parents had not been able to speak to the man to tell him it was not true. Therefore, the man named his girlfriend as his emergency contact.

17. A staff nurse then interviewed the man and completed the first reception health screen. However, the staff nurse did not have the community psychiatric nurse's report in front of him when he spoke to the man. It is not clear when this document arrived at High Down and was included in the man's records. The man told the staff nurse that he had been in hospital for the stab wounds. He had been discharged with paracetamol, tramadol (a pain killer) and fluoxetine (Prozac, an anti-depressant). However, he said that he had no concerns about his physical health. The next section of the health screen covers alcohol and drug use. The man said that he did not take drugs but abused alcohol by binge drinking.

18. The staff nurse then asked the man about his mental health. The man said that he had never had psychiatric treatment. However, he said that fluoxetine had been prescribed for his depression. When asked if he had ever harmed himself before, the man admitted that he had done so several times. He said that he had twice taken overdoses in 2000-2004, and had also attempted hanging and walking into the sea. When the staff nurse asked the man why he harmed himself, he replied that he was fed up messing up all the time and would like to end his life. He also described his mood as low and said he intended to harm himself.

19. At this point, the staff nurse decided to open an ACCT form and admit the man to healthcare as an in-patient. (The ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give the support needed through a period of crisis.) The staff nurse completed the 'concern and keep safe form' in the plan, listing his concerns about the man. He recommended putting the man in a gated cell where he could be more readily observed. The staff nurse explained in interview that he admitted the man to healthcare because his intention to self-harm was serious enough to need the continuous care available there. He also judged that the man needed level 2 observations (four times an hour), which was better done in healthcare. The staff nurse and an officer then took the man to the healthcare centre where the nurse gave a verbal handover to staff.

20. Healthcare staff then drew up an immediate action plan for the man that included letting him have full access to Listeners and the Samaritans telephone. He was put into a single cell that did not have bars at the windows and the observations began. An entry in the ongoing record early the next morning noted that the man had slept well all night.

21. Once an ACCT plan is opened, an assessment interview must be completed within 24 hours. An officer completed the man's assessment and care map the following afternoon. In his assessment the man said that his current problems were related to alcohol. He said that he had had support from his parents and that he felt guilty about his crime. When he had stabbed himself he had expected to die. However, he said he now felt it was good to be alive and was coping well. He told the officer that he had spoken to staff from

Counselling, Assessment, Referral, Advice, and Throughcare services (CARATs) about his problem with alcohol and said he "wants this sorted out." (CARATs teams provide drug misuse intervention services in prisons.)

22. In addition to the assessment, the first case review must also be held within 24 hours of the ACCT being opened. In the man's case, the first review took place on the morning of Friday 13 April, somewhat later than required. The man attended, along with two officers. The man's improvement in mood was noted and his outlook was described as positive. He told staff that he had no thoughts of self-harm and was eager to get on courses for his alcohol addiction.

23. By Saturday evening, the man appeared to have settled well. He had spoken to a Samaritan for a short time in the morning. (Samaritans and Listener conversations are confidential so it is not known what the man talked about.) Staff noted that he had taken part in exercise and association periods and had spent a lot of time reading a book. When he collected his medication at the hatch at 9.00pm, the nurse noted how much brighter his mood was. The man told her that he had no thoughts of self-harm. He added that if he started to feel that way he would ask staff for help. The man and the nurse agreed that the observations should be stopped. The following morning both the admission to healthcare form and the well-man assessment were completed.

24. Over the next four days, the man continued to take part in unit activities and was described by staff as "in good spirits". He slept well each night and gave staff no cause for concern. At an ACCT case review on the afternoon of 20 April, the man said that he was feeling better and had no thoughts of self-harm. The staff then decided that he was fit to leave healthcare. My investigator asked the in-patient manager who chaired the review what factors were considered in judging that the man was fit to leave healthcare. He said that patients had to be compliant with their medication and their mental health problems had to be stabilised. They also had to be physically well and not be thinking of self-harm.

25. The man told the staff at the meeting that he would like a single cell as sharing made him paranoid and this led to fights with other prisoners. Healthcare staff referred the matter to the duty governor who decided that the man should be allocated a shared cell. This decision is in keeping with Prison Service Order 2700 'Suicide and Self-Harm Prevention' which states that, "At risk prisoners should routinely be allocated to shared accommodation, unless the prisoner represents a risk to others, their behaviour is too disturbing to other prisoners or shared accommodation is not available."

Houseblock 3

26. The man then moved to a three-man cell in Houseblock (HB) 3. Another case review was held by the wing staff. The man told staff that he had no thoughts of self-harm as he only had such thoughts when he drank alcohol. He said that he wanted help to beat his alcohol addiction and was happy to be on normal location. Once on HB3, the man was allowed to have his medication

in his possession rather than attending the treatment hatch each morning to collect it. There is nothing to indicate whether the man took the medication as prescribed. However, the prescription chart shows that he was given a week's supply when he left the healthcare centre and on two subsequent occasions he collected a further week's supply.

27. On 24 April, the man had a legal visit. On his return, an officer asked him how he was doing, to which the man replied that he was 'okay'. The following day, he consulted a member of the healthcare staff as he was concerned about his stab wound. He was given an appointment to see a doctor the following morning. After the consultation, the doctor noted in his medical record that there was no redness or sign of an abscess around the scar.

28. When the man returned to HB3 he told an officer that his girlfriend was pregnant and was having health problems. The officer telephoned the girlfriend on the man's behalf and she said that she might have lost the baby. The following day, at an ACCT case review, the man told staff the news. He said that he was being given good support by officers and other prisoners and had "no current thoughts of self-harm". The care map was updated to include a plan for the man to look for work, as he was unemployed at that time and consequently spending a lot of time in his cell. In light of the news, the ACCT was kept open.

29. On 4 May, when the man was unlocked for exercise, he asked an officer if he could speak to someone. However, he refused the services of a Listener, then said he was okay and went out into the yard. The next ACCT review was held later that morning. The man told staff that he had received a 'Dear John' letter from his girlfriend the previous day. He said that he was "disappointed with being dumped" but was okay with it. However, the notes of the meeting also recorded, "he gets self-harm thoughts and suffers from mental health issues." On a more positive note, the man told staff that he was keen to work on the hotplate and was going to apply for this position. The ACCT remained open and a further review was scheduled for a week's time. That evening, he worked on the hotplate and an officer noted that he seemed in good spirits.

30. The following day, the man began working full-time on the hotplate. Hotplate workers have certain privileges, one of which is having a single cell. The man was not given a single cell at this point because he was still on an ACCT plan which, as noted, normally precludes being in a single cell. The man settled into the hotplate workers group and worked well as part of the team. He spoke openly to one or two of his colleagues about his past suicide attempts, including setting fire to his parents' home. In his statement to police after the man's death, one of the prisoners recalled a conversation with the man. The man had said that he was expecting to be sentenced to 10 to 12 years for the offence. He also said that he felt very guilty about destroying many irreplaceable family possessions. He felt it was unfair on his parents because they had been loving and supportive all his life.

31. On 6 May, an officer noted that the man was not happy that he was still in a shared cell but accepted that while the ACCT was open he would not move to

a single cell. Two days later, an officer had a long conversation with the man about his great desire for the ACCT to be closed. The officer said that the matter would be discussed at his next review in three days' time. The man said that he had been depressed when he came into prison because he felt that he had let everyone down. However, he now felt more positive about his future. They discussed the fact that the man had re-established contact with his parents, former partner and son. They talked about football and sport and the man asked the officer to help him with a magazine article that he was writing.

32. The man also told the officer that one of his cellmates was stealing tobacco and desserts from him. The officer offered to move the man to another (two-man) cell and begin anti-bullying measures against the cellmate. However, the man said that was unnecessary as he was able to deal with the matter himself. The cellmate was not threatening him - it was more a matter of the man using his possessions without permission. The man also did not want to move as his other cellmate would then have to deal with the problem on his own. He felt this would be unfair.

33. The ACCT review meeting on 11 May was chaired by a senior officer and attended by another officer and the man. Before holding the review, the senior officer spoke to the officer who had earlier had conversation with the man to ascertain how the man was getting on. The man told the staff that coming into prison had changed his life. He said he had resumed contact with his ex-partner and child, as well as his parents, which pleased him very much. However, he knew that when he returned to court he would probably be given a custodial sentence. He told the staff that, in spite of this likelihood, he was in very good spirits. After the discussion, it was decided to close the ACCT and the post-closure interview was scheduled for 18 May. That afternoon, the man moved into HB3 1A 11, a single cell on the ground floor spur that houses the hotplate workers.

34. Prisoners told my investigators that on either 15 or 16 May (their recollection of the date differed) the man had received a letter that upset him greatly from his girlfriend. In the letter the girlfriend told the man that she knew that he had begun a relationship with another woman shortly before he was arrested. The man showed it to one or two of the hotplate workers and then angrily ripped it into pieces. However, during 16 May, the man showed one of the hotplate workers a letter he had written in response. It was not to his former girlfriend but to a mutual friend. The tone of the letter was very measured and ended by wishing both the friend and former girlfriend all the very best. During the rest of the day he appeared to have cheered up. One of the prisoners described him as "perky" to my investigator. That evening, the man appeared fine as he showered shortly before being locked up for the night. The prisoner in the opposite cell said that they had joked in the shower room and the man had borrowed tobacco from him. As they each went to their cells, he felt that the man was "in good spirits".

35. A prisoner, who was in the cell next to the man, later told police that he could not sleep that night. He was awake at about midnight when he heard a noise

from a nearby cell. He described it as the pipes making a strange crashing sound. He knew it came from a cell close to his but could not be certain from which one.

Thursday 17 May

36. On Thursday 17 May, an officer started unlocking the cells of the hotplate workers shortly after 7.20 am. She began at the opposite side of the spur to the man's cell and worked her way round. As she unlocked each door, she said good morning to the prisoner inside. When she came to the man's cell at about 7.25am, she unlocked the door, greeted him and started to move on. As she did so, she realised that something was wrong, went back and entered the cell. She saw the man in a stooped position under the window and noted that his face was swollen and his lips were blue. She stepped out of the cell, blew her whistle for assistance and then unlocked the gate between the spur and the landing.

37. Two officers arrived at the cell and lifted the man to take his weight. A third officer entered and he also held the man whilst one of the other two officers opened the window to release the towel that was around the man's neck. A senior officer arrived at this point and she put a call out for the duty member of healthcare (call sign Hotel 2) to attend Houseblock 3 for a Code 1 (very serious) medical emergency. The officers laid the man on the floor and tried to cut the towel from round his neck. The anti-ligature knives did not cut through the thick towel, so an officer went to get the cut-down scissors from the office.

38. The senior officer then told the staff who were not involved in attempting to resuscitate the man to leave the cell to create space for those administering first aid. As soon as the man was on the floor, two officers tilted his head and tried to open his mouth to insert an airway to begin CPR. However, rigor mortis had set in and they were unable to do so as his jaw was shut tight. An officer noted that the man's face was a bluish colour, he felt very cold and his arms and legs were slightly bent. The officer who went for the scissors returned with them and handed the scissors to one of the officers in the cell to removed the towel from the man's neck.

39. The duty staff nurse was in the healthcare centre when she was informed by radio that there was a Code 1 emergency. She asked another staff nurse to accompany her and they set off with the bag of emergency equipment to HB2. She told my investigator that the information she was given was to attend a Code 1 on HB2. As they arrived, the duty nurse received a call to attend a Code 1 in HB3. When she queried whether this was a second emergency, she was told that it was not and that the correct location was HB3. There was then a few minutes delay while the nurses ran to the man's cell.

40. When they arrived, one of the staff nurses took over from the officer who was trying to fit the airway into the man's mouth. The duty nurse could not find a pulse. She also checked the man's breathing and noted his colour and temperature. Because of rigor mortis, she could not insert an airway to help

with his breathing. She asked for the Houseblock's oxygen cylinder to be brought to the cell and then began mouth to mouth resuscitation. When the oxygen arrived, the nurses struggled for a minute or two to attach the face mask to it before eventually succeeding. Both nurses knew that the man was beyond help but, at the officers' insistence, they began CPR. Two other staff nurses then arrived and took over the CPR until the paramedics arrived at around 7.50am. The paramedics examined the man and confirmed that he had died. At 9.40am, one of the prison doctors attended and formally recorded the man's death.

41. All staff who had been involved in finding and attempting to resuscitate the man attended a hot debrief at 10.00am. They took the opportunity to discuss several issues about their response.

Contacting the man's family

42. When the man arrived at High Down he had not given his parents' contact details as he had not nominated them as his next-of-kin. Instead, he gave staff his girlfriend's name, address and mobile phone number. After his death, when staff thought about whom to contact and how, they made a number of decisions based both on the details in the man's prison records and staff knowledge of recent developments in his private life.

43. Staff knew that the man was once again in touch with his parents and that his relationship with his girlfriend had ended. They therefore decided not to contact her but to break the news of the man's death to his parents. However, they could not obtain a telephone number for them. They asked both the police and a clerk at the man's solicitor's office for details but neither could provide a current address or telephone number. Eventually, the governor who is also head of residence, decided to ask the man's girlfriend if she could provide contact details for the man's parents. When he spoke to her, he did not give her any information about why he needed to contact the man's parents. The girlfriend gave him the man's mother's mobile phone number.

44. The head of residence then called the man's mother with the intention of asking for her address so that he and a senior officer, the prison's family liaison officer (FLO) could go and break the news in person. However, the man's mother immediately realised that something must be seriously wrong and asked the head of residence what had happened to the man. As the head of residence tried to avoid breaking the news on the telephone, the man's mother became increasingly upset and insistent. He therefore felt obliged to tell her of the man's death.

45. Once he ended the call, the head of residence prepared to travel to the family's home. However, he was very concerned about the man's mother and tried to find someone to offer her support until he arrived. He asked the local police if they could provide an officer to visit the family. He also spoke to staff at the local prison close to the man's family house to see whether their FLO could help out. Unfortunately, neither a police officer nor FLO was available.

46. The head of residence and a senior officer arrived at the man's parents' home about an hour later for what proved to be a very difficult meeting. Unfortunately, matters deteriorated further when the man's mother took strong exception to the claim that staff knew the man 'very well'.

47. After that first meeting, the family liaison role was taken on by a governor from HMP Coldingley. During her contact with the family, she answered many of their questions and provided good support. The man's family spoke very highly of her to my own family liaison officer.

ISSUES

Healthcare

48. The clinical reviewer examined the clinical care given to the man at High Down. She asked the PCT Inreach Services Manager, to assess the care given to the man as an in-patient in the healthcare centre, including his mental health needs. Both concluded that the care the man received when in prison was at least equal to that he would have received in the community. Indeed, the support he was given through the ACCT plan was better than he could have expected had he been at liberty. In spite of this, the clinical reviewer makes a number of recommendations for improving the service given to prisoners.

49. When the man arrived at High Down, his health needs, particularly his mental health needs, were assessed and addressed by the staff nurse in reception. The staff nurse opened an ACCT and admitted the man to the in-patient unit in the healthcare centre. However, these actions did not tally with the information he recorded in the 'Planned action' section of the First Reception Health Screen. In addition, two of the dates recorded on the form were incorrect.

    The Head of Healthcare should provide an update training session on record keeping for all healthcare staff.

50. The day before the man was discharged from the healthcare centre, healthcare staff completed a referral to the mental health in-reach team. This is routine practice. The reason for the referral was noted on the form as 'history of depression – self-harm on several occasions'. It added that the man had not self-harmed whilst an in-patient. However, the form appears to have been filed in the man's medical records rather then being sent to the in-reach team. As a result, the man did not have a mental health assessment during his time in prison.

    The Head of Healthcare should review the process for referral to the mental health in-reach team.

51. At court, prior to his reception at High Down, the man was assessed by a community psychiatric nurse. She concluded that he was not displaying any signs of a severe or enduring mental illness. However, he was showing signs of acute depression for which he was receiving medication. The man continued to take that medication while he was an in-patient and, although we cannot be certain, there is evidence that he continued to take it during his time on HB3. The PCT Inreach Service Manager concluded that it "…is not clear what support mental health in-reach would have been able to add." He added, "the practical support [the man] received through officers was reasonable and that his mental health was not such as to require specialist mental health follow up." However, the Inreach Service Manager felt that the issue was important enough to need a clear steer to staff on referrals for prisoners who have a history of self-harm and I agree.

The Governor should remind staff that, for prisoners with a history of self-harm, a full psychiatric history should be obtained and a referral made to mental health services.

ACCT

52. The man was at high risk of self-harm. In light of this, the reception staff nurse opened an ACCT plan on his reception at High Down. The man remained subject to the ACCT throughout his time in healthcare and for most of his time in HB3. The ACCT was appropriate and timely and the care map and assessment were completed as required.

53. However, maintenance of the ongoing record of significant events, conversations and observations was less satisfactory. The case manager instructed officers to record 'Quality entries twice daily and all handovers' and two entries each night. Whilst the quantity was achieved, quite a few of the entries were rather formulaic and merely described the man's activity rather than recording an interaction. However, there were a number of entries that showed the member of staff had spent time with the man talking over his concerns and describing the action taken. This should be the norm. The entries on 6 and 8 May which reflect the man's growing desire for the ACCT to be closed and to move to a single cell are examples of good entries.

54. My investigator discussed the quality of entries with the governor who is the Head of Residence and Safer Custody. He agreed that improvements were needed and said that additional training was being given to the senior officers who act as case managers. A revised version of PSO 2700 'Suicide and Self-harm Prevention' which is currently being introduced by the Prison Service, highlights the difference between interaction and observation. Interactions are required during the day and observations should only be used at night to avoid disturbing a sleeping prisoner.

The Governor should remind all staff of the importance of making detailed notes of their interactions with prisoners subject to ACCT monitoring.

55. Another area of concern is that the case reviews were not multi-disciplinary. PSO 2700 states:

> "The manager of the unit where the prisoner resides must:
> - Ensure further multi-disciplinary case reviews are held as necessary …
> - Seek guidance from healthcare staff and co-operate with related case reviews and with those in other departments."

The guidance in the ACCT booklet (Section One) reiterates that the care must be multi-disciplinary. However, once the man left healthcare, the review meetings were attended only by wing staff and the man. No representatives

from healthcare or any other department in the prison were present, even at the review that closed the ACCT plan.

The Governor should ensure that the ACCT training for case managers covers the necessity of providing multi-disciplinary care.

56. The aim of opening an ACCT plan is to provide additional support for a prisoner to see him/her through a period of crisis. It is not a long-term measure as, while an ACCT is open, staff should encourage the prisoner to build up a support network and develop coping strategies in preparation for the closure of the plan. Before the plan is closed, certain conditions must be met. Staff must ensure that the problems that caused the ACCT to be opened have been resolved or significantly reduced in intensity. They should also check that the prisoner has access to some resources that they 'find life promoting'.

57. At the case review on 11 May, the man told staff that coming into prison had 'changed his life'. He had re-established contact with his parents and his former partner and was speaking positively about the future. He had begun working on the hotplate and was fitting well into the team. He was also writing for a prison newspaper and had interviewed staff and prisoners as research for his article. The man had not attempted to harm himself at High Down and he was happy for the ACCT to be closed. As the criteria for closing the ACCT had been met, the staff and the man decided to close the plan. Once an ACCT has been closed, a review meeting must be held. The senior officer scheduled one for 18 May.

58. The decision to close an ACCT is a serious matter. In the man's case, I am satisfied that the necessary conditions had been met and that the decision was reached after careful consideration. It is a great sadness that the man died only six days later. However, when the ACCT was closed, he was showing no signs of depression or any intention to harm himself. Neither did he give anyone cause for concern from 11 to 16 May. I therefore conclude that the closure of the ACCT was appropriate.

59. The decision to move the man to a single cell followed on quickly from the closure of the ACCT. Staff closed the ACCT plan because they considered that the man showed no signs of wanting to self-harm. Because he was no longer seen as at risk and was not on an ACCT plan, staff decided that he should be allowed to move into a single cell. However, caution should always be taken to ensure that decisions on cell sharing after closure of an ACCT plan are not made automatically but after due consideration.

Resuscitation

60. When the Code 1 call requested healthcare staff to go to the man's aid, there was confusion about the location. The nurses went from the healthcare centre to HB2, which is in the opposite direction to HB3. It was only when a staff nurse received a second Code 1 message that it became evident that the emergency was in HB3. The confusion delayed the nurses' arrival by several

minutes. The Governor may wish to review the emergency call system with a view to ensuring messages are sent and received clearly.

61. Once they began CPR, the duty staff nurse asked for the oxygen cylinder to be brought from the wing office. She then attempted to attach a face mask to the cylinder so that she could deliver oxygen to the man. However, she struggled as the method of fitting was not obvious and it took a minute or two to attach it. Nursing staff informed their manager of this in the debriefs afterwards. As a result, the oxygen cylinders have been replaced by new ones with a different, and easier, means of connection.

62. These delays are regrettable. However, it is likely that, even if there had been no delays, the outcome would have been the same. It would appear from the statements of the staff who found and treated the man that he was already dead by the time he was discovered.

63. Annex C of PSO 2700 sets out instructions on the correct emergency procedures for staff who discover a prisoner has self-harmed. For hanging it states:

> "If not breathing and/or no pulse is present, clear airway and attempt resuscitation, using a face mask with non-return valve, unless rigor mortis of the limbs has clearly set in." (Emphasis in original.)

The clinical reviewer discusses the fact that staff saw that the man's arms and legs were locked in position due to rigor mortis which prevented them from moving his limbs. However, healthcare staff felt under considerable pressure from the uniformed staff to continue the resuscitation attempt.

The Governor and Head of Healthcare should remind all staff of the instructions in PSO 2700 that resuscitation should not be attempted when rigor mortis is present.

Contact with the man's family

64. The man entered High Down under the mistaken impression that his parents had severed contact with him. As a result, he did not give their contact details as his next-of-kin. Instead, he listed his girlfriend and gave her address and telephone number to be used in an emergency. Over the following month, mainly through the ACCT process, staff learned that the man's relationship with the girlfriend had ended and he was again in contact with his parents. After the man's death, managers at High Down decided to treat his parents as next-of-kin rather than the girlfriend.

65. When a prisoner dies, PSO 2710 states that prison managers must:

> "Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened."

Managers are under great pressure to contact the next-of-kin as soon as possible to prevent the news reaching them unofficially, for example through being told over the phone by another prisoner.

66. As already mentioned, the man's prison records did not contain his parents' contact details. Managers spoke to the local police to try to get the man's parents' address. However, the only information available was for their previous family home that had been badly damaged by the fire. Managers told my investigator that they also rang the man's firm of solicitors but they could not provide an address. The man's solicitor told my investigator that she personally had not spoken to anyone from the prison. However, it was quite possible that it was her clerk that took the call. Finally, the head of residence called the man's former partner to ask her if she had any contact details and she provided the man' mother's mobile phone number.

67. PSO 2710 states:

> "Using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort."

The recommended method is for the family to be informed face to face as soon as possible after the death. However, in spite of all his enquiries, the head of residence could not obtain an address for the man's parents. He therefore called the man's mother on her mobile phone to ask for her address and inform her that he needed to visit her.

68. When the head of residence introduced himself to the man's mother, she immediately knew that something was seriously wrong and asked what had happened to the man. Bearing the PSO in mind, the head of residence tried not to break the news of the man's death during the conversation. However, the man's mother insisted he tell her what was wrong and became increasingly distressed when he held back the news. Eventually, the head of residence felt that his only option was to tell her that the man had died. The fact that the man's mother had to insist on being told the news added considerably to her distress.

69. At interview, the head of residence agreed that, with hindsight, he would have liked to have done things differently. However, once he had begun the conversation with the man's mother, there was no way to avoid giving her the news. The PSO states that breaking the news by telephone should only be a last resort. The particular difficulties in obtaining the man's parents' address and the necessity of contacting them as quickly as possible were, in my opinion, justification for departing from the normal protocol. On this occasion, I believe the head of residence was right to break the news by telephone. However, I entirely understand the distress this all caused to the man's parents. The Governor may wish to write to them in light of the findings of this report.

70. After he had spoken to the man's mother, the head of residence was concerned that there would be a delay of about an hour before he and the

prison's FLO would arrive at the man's parents' home. He tried to cover the gap by getting a police officer or an FLO from the local prison to be with the family until he arrived. However, this proved impossible to arrange. The head of residence and the senior officer who managed the staff who attempted to resuscitate the man, who is also the FLO, then visited the man's parents. During the meeting, the man's mother became further distressed at the claim that staff on the wing knew the man 'very well'. She told my FLO that it was an insensitive and insulting comment as the man had been on HB3 for less than a month.

71. The prison's initial contact with the man's parents caused the family great distress. This was not through deliberate policy but as a result of the difficulties in finding an up to date address and the need to contact the family with all due haste. I have been pleased to learn that senior managers have already looked at ways of improving their responses. For this reason, I do not believe I need make any recommendations on this point.

Family liaison provision

72. At the time of the man's death, High Down had only one FLO – a senior officer. She had completed her training but had never undertaken FLO duties. Having only one FLO in post created a number of problems for everyone concerned.

73. The senior officer was the first manager to arrive at the man's cell. She took charge of the resuscitation attempt, calling the Code 1 and ambulance and directing the staff. Once the resuscitation attempt had ended she moved straight into her duties as FLO for the man's family. While other staff were sent home in recognition of their involvement in traumatic events, the senior officer was asked if she felt capable of going with the head of residence to visit the man's family. To her credit, she agreed to do so, but it would have been better not to have put her in that situation. While I acknowledge the pressures on prison managers, I consider that they asked too much of this senior officer.

74. After the visit, the head of residence acted quickly to provide better support for the family. He arranged for a governor at Coldingley to take over the family liaison role. It is greatly to the governor's credit that she developed a good relationship with the parents of the man and provided them with excellent support.

75. The second consequence of the minimal FLO provision was that High Down did not ever contact the man's former girlfriend. Once the man's parents had been notified, it would have been good practice for managers to have broken the news to the man's former girlfriend. Although the relationship had ended, she was still the man's emergency contact. I agree with the decision that, in the circumstances, the man's parents should have been regarded as his next-of-kin and been notified as soon as possible. However, I disagree with the decision not to tell the girlfriend. The main consideration appears to have been the letter she wrote to the man ending their relationship. However, another factor in the decision was that there was no FLO to liaise with her.

The governor who accepted to be FLO for the man's family was fully employed in supporting the parent's of the man and there was no-one else available. The man's former girlfriend learned of the man's death through a mutual friend. She described feeling unsupported by officials when subsequently contacted by my FLO.

76. High Down currently has around 750 prisoners and a further two houseblocks are under construction. I consider that a local prison of this size requires a team of FLOs to ensure sufficient cover. Having several trained staff allows for flexibility in assigning FLO duties, and provides mutual support for the staff taking on such an important and demanding role. The head of residence told my investigator that he is currently recruiting more FLOs as a direct result of the lessons learned after the man's death.

The Governor should appoint a team of trained FLOs as soon as possible and provide the team with appropriate support mechanisms.

RECOMMENDATIONS

The Head of Healthcare should provide an update training session on record keeping for all healthcare staff.

This recommendation was accepted. The response was, "Training took place on the 9th of January 2008. All participants signed to say they had attended the training. It was well evaluated and we aim to hold the same training session 2-3 times per year."

The Head of Healthcare should review the process for referral to the mental health in-reach team.

This recommendation was accepted. The response was, "A full mental health action place is in place. Recruitment in our in-patient service will in future be carried out by the local Mental Health Trust for RMN's. Follow up once on the wings will be linked to their in-patient stay. If it is a new referral a process is now in place from the house block nurse to In-reach. It is also anticipated that we will have an electronic patient record by February 2008."

The Governor should remind staff that for prisoners with a history of self-harm, a full psychiatric history should be obtained and a referral made to mental health services.

This recommendation was accepted. The response was, "A Governor's order will be issued to update the staff and managers, to remind them that Prisoners who self harm should be referred to in-reach.

In-reach will arrange assessments and obtain information on psychiatric history."

The Governor should remind all staff of the importance of making detailed notes of their interactions with prisoners subject to ACCT monitoring.

This recommendation was accepted. The response was, "The safer custody team have issued a pocket guide on ACCT procedures to all staff on their payslips
The Safer custody will issue information to staff with regards to recording of interaction with prisoners who are on ACCT."

The Governor should ensure that the training for case managers covers the necessity of providing multi-disciplinary care.

This recommendation was accepted. The response was, "The safer custody team are arranging case manager training for staff who will be working as case managers or are required to be trained to that level to meet the standard in PSO 2700."

The Governor and Head of Healthcare should remind all staff of the instructions in PSO 2700 that resuscitation should not be attempted when rigor mortis is present.

This recommendation was accepted. The response was, “Training in resuscitation and defibrillation is carried out on a rolling programme so that staff are regularly updated. This instruction will be added to future training.”

The Governor should appoint a team of trained FLOs as soon as possible and provide the team with appropriate support mechanisms.

This recommendation was accepted. The response was, “An additional person has been trained as a FLO. Several applications have been received and currently awaiting space on a training course.”