PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in June 2012, while a prisoner at HMP Northumberland

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is a report into the death of the man who was found hanging in his cell at HMP Northumberland in June 2012. I offer my condolences to his family and friends.

The investigation was carried out by on of my investigators. A clinical reviewer was appointed to review the man's clinical care while in custody. HMP Northumberland cooperated fully with the investigation.

The man had a history of mental illness and had previously self-harmed. He had been recalled to prison in July 2011, to serve the remainder of a five year sentence after breaching his licence conditions in the community. At the time of his recall he was not monitored as a risk of suicide and self-harm although he was a very high risk. During his time in custody he had regular appointments with the mental health team and a visiting psychiatrist. In October 2011, a psychiatrist noted that the man's static risk of suicide was very high because of a range of factors including family history of suicide, his illness and past substance misuse. However, the man was generally regarded as presenting well, although often distressed by the symptoms of his illness. The man received good support from the mental health team at the prison and the clinical review found that the man received a standard of clinical care which was equivalent to that which he could have expected in the community.

Allegations after his death, that the man had been the victim of bullying for tobacco and medication were not able to be substantiated.

While there is no indication this would have changed the outcome for the man there were some deficiencies in the emergency response which need to be addressed.

The man was objectively a high risk of suicide but I am satisfied that he received a good deal of mental health input. He was not subject to monitoring under suicide and self-harm procedures at the time of his death and never gave any indication to staff that he intended to take his own life. To that extent, I agree it would have been difficult to foresee his actions.

The version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2013**

CONTENTS

Summary

The investigation process

HMP Northumberland

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was born in September 1977. He had a history of mental illness and had a number of previous convictions dating back to 1992. In 2009 he received a five year prison sentence and was released on licence from HMP Northumberland on 27 May 2011.

2. The man was recalled to custody on 21 July 2011, to serve the remainder of his sentence (until 25 November 2013), as he breached his licence conditions. He was initially taken to HMP Durham before being returned to HMP Northumberland on 19 August.

3. During his time in custody the man was regularly assessed by the mental health team and the visiting psychiatrist. He was prescribed anti-psychotic and anti-depressant medication. He regularly reported hearing voices but consistently said that he had no thoughts of harming himself or taking his own life. Prison and healthcare staff had no concerns about his risk to himself and he was not monitored under suicide prevention measures.

4. At approximately 10.40am in June 2012, officers found the man hanging in his cell and called for emergency medical assistance. Cardiopulmonary resuscitation (CPR) was attempted until paramedics arrived and took over his care. After a period of assessment and emergency treatment, at 11.21am the prison doctor confirmed that the man had died.

5. We make four recommendations about the risk assessment on recall, emergency procedures and the need to debrief staff effectively after an incident.

THE INVESTIGATION PROCESS

6. On 19 June 2012, the investigator issued notices in the prison about the investigation inviting anyone with information to contact him. No one came forward as a result.

7. The investigator visited HMP Northumberland on 25 June and obtained copies of all documentation relating to the man. He returned to Northumberland on 4, 5, 17, 18 July and 30 August to interview 11 members of staff and five prisoners. Written feedback was given to the Governor on 15 July.

8. A clinical reviewer was appointed to carry out a review of the man's clinical care. The investigator and the clinical reviewer discussed aspects of the man's treatment during his time at Northumberland and jointly conducted interviews. The clinical review report is annexed to this report.

9. The Coroner was informed of the investigation and will receive a copy of the investigation report to assist his enquiries. At the time this report was issued the post-mortem report had not been received.

10. One of our family liaison officers contacted the man's father to inform him about the investigation. He had no specific issues which he wished the investigation to take into account.

HMP NORTHUMBERLAND

11. The merger of two separate adjacent prisons, HMP Acklington and HMP Castington was announced in 2010, and work began to integrate all of the functions in April 2011. On 31 October 2011, the merged prisons became known as HMP Northumberland. HMP Northumberland accommodates up to 1348 adult male prisoners. The man lived in the part of the prison which was formerly HMP Acklington. Health services at the prison are provided by Care UK, a private company. The prison has a nursing health care team, a mental health in-reach team, also drug treatment, dental and pharmacy services.

12. Because HMP Northumberland is recently formed, there are not yet any relevant published reports from HM Inspectorate of Prisons or the local Independent Monitoring Board covering the new role of the prison.

13. This office has investigated seven other deaths at Acklington/Northumberland since 2008. Although the circumstances were very different, we have previously made recommendations about emergency response procedures in two other investigation reports.

KEY EVENTS

14. The man was born in September 1977. He had a history of mental illness and a number of previous criminal convictions dating back to 1992. In 2009 he received a five year custodial sentence. He was released from HMP Northumberland on 27 May 2011, on licence. (This means he was required to comply with certain stipulated conditions of his release or risk being recalled to prison).

15. On 21 July 2011, the man was arrested for breaching his licence conditions by not returning to his approved premises (probation hostel) by the curfew time. This meant he would have to serve the remainder of his sentence, till 25 November 2013, in custody. The next day the man was taken from police custody to HMP Durham. The Person Escort Record (PER) noted that the man had a history of violence, was schizophrenic and had attempted suicide by taking an overdose in 2006.

16. The man went through the routine reception and induction procedures at Durham. He told a nurse that he was prescribed olanzapine (for the treatment of schizophrenia) and citalopram (for depression) and had spent time in a psychiatric unit in 2007. Dr A assessed the man at Durham that evening. The man said he had been in prison eight weeks earlier, suffered from schizophrenia and heard voices. The man said he had no thoughts of harming himself. The doctor prescribed olanzapine and citalopram, to be issued daily, and requested the man's community health records. When these were received they confirmed the medication was in line with his community prescription and that no other medication was required.

17. On 27 July, Nurse A, conducted a mental health assessment when the man told her he heard voices which affected his sleep. He said he did not want to socialise with other prisoners. The nurse referred the man to the doctor for his sleep problems and arranged to see him again the next week.

18. On 28 July, Dr B examined the man and prescribed promethazine (for insomnia) for five nights, which he reviewed at a follow up appointment on 5 August. The man told the doctor that the voices were still keeping him awake at night. The doctor prescribed zopiclone (for insomnia) for four nights.

19. Nurse A saw the man on 9 August for a mental health review. The man said that he still heard voices which interrupted his sleep and that he had suffered with this for eight years. The nurse discussed different self-help techniques to manage the voices. She told him she thought it was important for him to come out of his cell at association times and to go outside in the open air during exercise periods. The nurse recorded that the man had no thoughts of self-harm or suicide.

20. On 19 August, the man went back to HMP Northumberland. The PER detailed his history of violence, mental health issues and previous self-harm. Nurse C saw the man in reception. As he had mental health issues and had been prescribed olanzepine and citalopram she referred him to be seen by the

mental health team. Nurse B from the mental health team (MHT) assessed the man on 24 August. The nurse recorded that the man was well known to the mental health team from his previous sentence and that there were no current concerns. A follow up appointment was arranged.

21. Nurse C, from the MHT told the investigator that the man had seen the MHT regularly when he had been at the prison from 2010 until his release in May 2011. She described the man's main problem as hearing voices in his head that said awful things about him. On 5 September, the nurse recorded that the man appeared anxious and said that he heard voices more at night. The nurse noted that she would review the man regularly. On 12 October, the man told the nurse that the voices had become more intrusive and were disturbing his sleep. The nurse told the man that she would arrange for him to see the visiting psychiatrist and that she would speak to the prison doctor about night sedation medication. Dr C, a prison doctor, prescribed zopiclone for three nights only, to be issued and taken on alternate nights.

22. On 18 October, Dr D, the visiting consultant psychiatrist, saw the man with Nurse C. The doctor recorded that the man had a history of schizophrenia and depression and was prescribed olanzapine and citalopram. The man said he had self-harmed "lots of times" by taking overdoses in response to the distress of hearing voices and to seek help or end his suffering. The doctor also recorded that the man's suicide risk was very high due to his family history, his illness and past substance misuse. The man told the doctor that he had no current thoughts of self-harm or suicide. The doctor noted that the man understood the risks and benefits of his medication and that he wanted to continue with the anti-psychotic and anti-depressant medication. He considered the benefits of clozapine (an atypical anti-psychotic drug which has been found to reduce the risk of suicidal behaviour in people with schizophrenia) but noted that the man would not be able to be safely titrated onto it in prison and he was unlikely to get an acute medium secure bed for this purpose. The man was also wary of a change to another anti-psychotic drug. The doctor increased the dosage of olanzapine from 20mg to 25mg, ordered blood tests and agreed that the man should continue to be reviewed regularly by Nurse C. The doctor also commented that the prescription of olanzapine could be increased to 30mg but any greater would require a review by a psychiatrist. The results of the blood tests were normal and no further action was required.

23. Between 29 October and 13 February 2012, the man had six further mental health reviews with Nurse C. He continued to receive his medication daily and no concerns were noted. Officer A, the man's personal officer (a nominated officer to support prisoners and to act as their usual first point of contact for prison issues) made regular entries in the man's computerised record. He noted that the man was quiet and only mixed with a small number of fellow prisoners, attended employment in the workshops, adhered to the prison regime, was polite and co-operative with staff and did not cause any concerns.

24. On 14 February, the man saw Dr E, a consultant forensic psychiatrist, accompanied by Nurse C. The man said that his symptoms were no better and

described the voices inside his head. He also said that his mood was up and down. He had no problems with his appetite, but had difficulty sleeping. He said he enjoyed his job in the workshop. The doctor recorded that he had concerns about the long term effects of citalopram and would review the man's medication in two weeks. The doctor prescribed a short course of zopiclone to aid his sleep. The doctor recorded that in his opinion there was no need to open an ACCT (Assessment Care in Custody and Teamwork, which is the Prison Service process for monitoring and supporting those considered at risk of suicide or self-harm). After the doctor's consultation, Dr F, a prison doctor, prescribed zopiclone for seven nights.

25. Between 15 and 27 February, the man continued to receive support from Nurse C and was prescribed zopiclone for a further three nights. The man was also twice excused from attending work as he told nurses that the voices in his head were troubling him and he wanted to rest in his cell. Dr E saw the man on 28 February, and his citalopram prescription for depression was changed to sertraline, to begin at 50mg for the first seven days and then increase to 100mg.

26. Between 1 and 26 March, Nurse C had two reviews with the man, he was prescribed a three night course of zopiclone and he was excused from work three times, again because he was unable to cope with the voices in his head. Dr E and Nurse C saw the man on 27 March when he told the doctor that he still heard voices but he had felt better since taking sertraline. He explained that he no longer worked in the workshop due the voices in his head but had asked to do something else. He also said that zopiclone had helped him to get a good night's sleep. The man's sertraline was increased to 150mg per day and he was also prescribed promethazine (an antihistamine that can also be used to treat insomnia) at 25mg each night.

27. Dr E explained that he tended not to prescribe zopiclone or other hypnotic medication and the man only had zopiclone prescribed for short periods of time to minimise the risk of him becoming dependent on the medication. The doctor said that in the prison setting he preferred to prescribe promethazine because it is non-addictive.

28. Between 28 March and 7 May, the man had two reviews with Nurse C, one with Dr E and was prescribed two short periods of zopiclone. He also started work in the Prisons Information Communication Technology Academy (PICTA) workshop, though he did not attend on five occasions because of the voices in his head.

29. Officer B became the man's personal officer on 29 April. The officer told the investigator that the man kept himself to himself and his only known friend was a fellow prisoner, A. The officer said that though the man was employed in the PICTA workshop he had been excused attendance by healthcare staff a number of times. Other than that he had no concerns about the man.

30. On 8 May, Nurse C saw the man and told her that he had benefited from taking zopiclone but he had recently experienced some bad days with the voices in his

head. Nurse C asked the man to keep a daily record of his mood and thoughts until she saw him two weeks later.

31. The man again told nurses he was unfit to attend the workshops due to the voices in his head on 11, 14, 16 and 18 May and was allowed to stay in his cell. During this period Officer B noted in the man's record that he had days absent from PICTA, but there were no other concerns or issues.

32. On 23 May, Nurse C saw the man on the wing as he had declined to go to see her in healthcare. The nurse recorded that the man was cheerful, smiling and made good eye contact. However, he said he was having a bad day with the voices in his head. He did not have to attend the PICTA for two weeks as the tutor was on leave. The man had not kept a record of his mood and thoughts as the nurse had requested. The nurse asked him to complete a mood thought diary so that Dr E could read it at his next consultation. The nurse also recorded that the man said he had no thoughts or intention to harm himself or attempt suicide.

June 2012

33. On the 7 and 8 June, the man was authorised to rest in his cell as he told nurses administering medication that he was again experiencing voices in his head. Dr E and Nurse C saw the man on 12 June. The man said he found it increasingly difficult to cope with the voices in his head. The doctor recorded that the man was distressed and that olanzapine did not help the symptoms he described. The doctor decided to change the man's anti-psychotic medication to risperidone. The doctor proposed to reduce the prescription of olanzapine from 20mg to 15mg on 13 June, on 14 June reduce to 5mg and start risperidone at 1mg and finally, on 15 June, completely stop the olanzapine and increase the risperidone to 2mg. No changes were made to the prescribed amounts and frequency of sertraline or zopiclone. The doctor planned to review the man a week later. The doctor again recorded that he saw no need to open an ACCT, but he would have a low threshold to opening one if the man's mental state deteriorated as a result of the change in medication. The nurse assessed the man as unfit to attend the workshops for an indefinite period. The doctor told the investigator that neither he, nor any other member of the mental health team, were concerned at that time that the man had any suicidal thoughts.

34. On the morning of 13 June, Nurse C saw the man as he wanted to discuss the change in his medication and whether he was still prescribed zopiclone. The nurse recorded that she had explained the change process for the man's medication, that she would give him the detail in writing and that there was no change to his prescription for zopiclone.

35. Later that afternoon, Nurse C had an urgent request from wing staff to see the man as he had smashed his cell television over the toilet in his cell and damaged the toilet. The man told the nurse that voices had told him to do it. The nurse recorded that the man was calm and relaxed and showed no outward signs of distress. She advised him to use distraction techniques and

told him that the change in his medication would need time to take effect. The man said that he had no thoughts of harming himself. As the man had damaged the toilet he was moved to another cell on the same landing. Because of the man's mental health issues no formal action was taken, but in line with the prison's usual policy for damaged televisions, he was not allowed another television for seven days. No consideration appears to have been given to whether this was appropriate when part of the man treatment was to have distractions, which a television might have helped with.

36. On Friday 15 June, Nurse C saw the man. She noted that the man said the voices were tormenting him and he felt that was because he was no longer taking olanzapine. The nurse encouraged him to use distraction techniques and to take risperidone. The nurse told the man she would see him again the next Monday and she gave him some puzzles to do over the weekend to assist with his distraction techniques.

37. Officer C who was on duty on the wing on Saturday 16 and Sunday 17 June, told the investigator that the man appeared his usual self and he had no concerns about his wellbeing.

Events of Monday 18 June

38. At approximately 9.00am, Nurse C saw the man on the healthcare unit and spent about 30 minutes with him. The man said he had slept better the previous couple of nights and this eased the voices. He said that he had played music as a distraction rather than doing puzzles. The nurse recorded that the man said he had no thoughts of self-harm or suicide. At his request she agreed to attend his consultation with Dr E the next day.

39. The man returned to the wing and went into his cell at approximately 9.55am. Officer D went around the wing to lock the cell doors of the prisoners who had returned from healthcare. The officer told the investigator that when he reached the man's cell he looked through the observation hatch and saw the man sitting on his bed.

40. At approximately 10.30am, Officer D began the routine cell fabric checks. When he came to the man's cell at approximately 10.41am he opened the door but it moved only very slightly. Initially, the officer thought that the man had placed some sort of barricade behind the door to prevent anyone entering the cell. The officer looked through the observation panel and saw no sign of a barricade or the man.

41. Officer D realised that something was seriously wrong and that the man might be hanging behind the door. He did not have a radio so he shouted to prisoner B cleaning on the wing, to go and get staff and tell them code blue (an emergency signal that informs staff that a prisoner has been found not breathing or with breathing difficulties). The officer squeezed through the gap in the door and found the man suspended from the top of the door hinge by a noose around his neck made of torn strips of bedding. The officer supported the man's body with his left arm and cut the noose using his anti-ligature knife.

The officer was unable to hold the man's full weight and his body slumped to the floor still behind the cell door, which pushed the cell door shut. Although the officer was not first aid trained he checked for signs of a pulse and breathing but was unable to find any. The officer attempted to move the man away from the door but was only able to move him sufficiently so that the cell door opened slightly.

42. The general alarm was sounded and Officer C radioed a code blue at 10.42am. Officer C, Officer F and Acting Senior Officer (ASO) A arrived at the cell at 10.42am. Officer D told them that he thought the man was dead. The ASO thought that Officer D was in shock and told him to leave the area and to get a drink. Officer D, who was also not first aid trained, checked the man for vital signs but was unable to find any. At the ASO's request Officer C cut the noose from the man's neck and left the cell at 10.45am.

43. ASO A told the investigator that he was first aid trained but when he went into the cell he suffered a flashback to a similar incident that he had been involved in 12 months previously. He said he had had to come out of the cell to gather his thoughts.

44. Nurse D and Nurse E were in the healthcare centre when they heard the call. Because of the size of the prison site it took them several minutes to get from the healthcare centre to Houseblock 7. When they arrived, at approximately 10.47am, the nurses collected the emergency equipment from the treatment room and went to the man's cell. The man was still behind the cell door and the nurses needed help from officers to move him to the middle of the cell to begin resuscitation. Nurse F arrived shortly afterwards and ensured an emergency ambulance was called. The call was made at 10.52am.

45. The nurses started CPR and used an automated external defibrillator (AED) (which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary) which advised that there was no shockable rhythm. The nurses said that it was apparent that the man was already dead when they arrived, but they started CPR in line with nursing protocols.

46. Paramedics arrived at 10.59am and took over the man's care and continued CPR. Dr F came to the man's cell and after discussion with the paramedics at 11.21am pronounced that the man had died.

Contact with the man's family

47. At 2.10pm, the prison family liaison officer, accompanied by an operational manager at the prison, went to break the news of the man's death to his father and to offer support. The prison maintained contact with the man's father in the following days and offered support and help with funeral expenses.

Support for staff and prisoners

48. Prison Service instructions require a senior member of staff to hold a “hot debrief” meeting to offer reassurance, information and support for all the staff involved in an emergency, but a debrief was not held. However, support was made available to staff from the local care team and the national Prison Service Employee Support Service. After the man’s death prisoners were offered support from the chaplaincy, IMB or the Samaritans. All prisoners who were being monitored on ACCT plans were reviewed in case they had been adversely affected by the man’s death.

49. An ACCT was opened for prisoner A, the man’s friend, by Officer F who was concerned about his wellbeing after the man’s death.

Events after 18 June

50. After the man’s death anonymous allegations were made by prisoners that the man had been bullied for tobacco by two prisoners, C and D. When prisoners borrow tobacco from other prisoners this can lead to bullying as the debt is often enforced by prisoners who expect twice the amount back, known as ‘double bubble’. Two other prisoners, E and F, told staff that the man had been bullied by G for tobacco, and that prisoner G also sold medication to a number of prisoners on the wing including to the man.

51. The prison investigated these allegations and prisoner G was dealt with under the prison’s Anti-Social and Unacceptable Behaviour Strategy and moved to the segregation unit initially. Subsequently, no evidence was found to support the allegations that he had bullied the man. No action was taken against Mr C or prisoner D as no evidence was found to support the allegations against them.

52. Prisoner F told the investigator that the man was a quiet person who kept himself to himself and he never saw him playing pool or socialising with other prisoners. Prisoner F said that he was aware that the man was in debt to a number of prisoners for tobacco and could not pay all of them back. In particular Prisoner F said the man told him that he owed tobacco to Prisoner C.

53. Prisoner A told the investigator that he and the man had become good friends and spoke regularly. He said that the man filled his time by listening to music and going out on exercise. The man told him about his mental illness, his offence, his father and that he could not see his children. He said that the man told him that he was in debt to prisoner D, and prisoner C, and to a lesser degree prisoner G, for tobacco and used his sleeping medication as part payment of the debt. He said that he was aware that bullying had taken place for a few weeks before the man’s death.

54. The investigator interviewed the three prisoners against whom the allegations were made. Prisoner C said that he did not smoke and he had not given the man any medication. He said that the man told him that he needed medication to sleep and bought it from prisoners D and G and repaid them with tobacco.

55. Prisoner D told the investigator that he was not aware that the man was being bullied by anyone. He said that he used to give the man a couple of cigarettes occasionally if the man had offered him a sandwich at lunchtime. He also said he had never given or sold his medication to the man. He said he was aware that the man was in debt to other prisoners for tobacco and that a couple of days before the man's death there had been an argument between prisoners C, G and the man over the repayment of tobacco, but it had blown over by the next day.

56. Prisoner G told the investigator that he was prescribed tramadol (for severe pain relief), as well as inhalers and medication for epilepsy. He said that other prisoners, including the man, had asked to buy his tramadol but he had not given them any. He said that he was aware that the man bought medication from prisoner D and this had to be repaid in tobacco.

57. The wing staff that the investigator interviewed all said that they saw no signs that the man was bullied and he had not raised any concerns with staff. The prison's family liaison officer said that when the information was received after the man's death the decision was taken to temporarily move prisoner G to the segregation unit.

ISSUES

Assessment of risk

58. We have considered whether staff should have monitored the man under the ACCT process during his time in custody from June 2011. The man had been recalled to prison, which is a known risk factor for self-harm. He suffered from schizophrenia which is strongly associated with an increased risk of suicide and he was being treated for depression. His mother had killed herself when he was a child. He tended to isolate himself, had little family contact, had previously abused drugs and alcohol and had made previous suicide attempts. All these are factors which increase the risk of suicide and self-harm. On 18 October 2011, Dr D, a psychiatrist, noted in the man's medical record 'Suicide risks demographically very high due to family history, illness, substance misuse etc and also acutely high while has psychotic symptoms but currently engaging with treatment' the doctor also noted 'Can't safely have clozapine which may otherwise be indicated.' The National Institute for Clinical Excellence (NICE) has said that using clozapine can reduce the risk of suicide in people with schizophrenia but the doctor noted that the man could not be 'safely titrated onto it (clozapine) in prison and he is unlikely to get an acute medium secure bed for this purpose.' The doctor explained to the investigator, that while clozapine is very effective its side effects can be fatal. He said the medication had previously been prescribed to people in the community as day patients in hospital, but he would only prescribe clozapine to an inpatient in a hospital with acute facilities.

59. The man had been in prison before and his prison records show that he had taken a drug overdose in 2006 and was monitored on an ACCT at that time. This was the only time in the man's custodial history that he had been monitored under the ACCT process.

60. The man's mental state and risk of self-harm or suicide was assessed regularly by Dr E and Nurse C, including on the morning of his death, and neither had any concerns about him that suggested he needed to be monitored under ACCT procedures. The doctor said that he had a low threshold for opening an ACCT and would have done so if he had any reason to be concerned. At interview he referred the doctor's assessment of the man's risk of self-harm but said there was nothing at the time he made changes to his medication, which he accepted was a risky time, that made him particularly concerned that the man was becoming more despondent. The doctor said the man was distressed by his experiences but not so acutely psychotic he could not function. While he considered the man's condition as chronic he had no indication that he was going to commit an act of deliberate self-harm. Nurse C who spent about half an hour with the man on the morning he died said she had known him since 2010 and that he gave no indication of what he was going to do. She said there was nothing about his presentation that gave her any reason to think he intended to harm himself.

61. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national

assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. While the man had a number of static risk factors there was nothing about his particular presentation in June 2011 which indicated increased risk. Using the static factors alone might have suggested that the man should have been on a constant ACCT, but that would have negated its effect. The change in his medication appeared to have caused him some distress, but not sufficient so that healthcare staff who knew him well considered that an ACCT should have been opened. The man consistently denied any thoughts of self-harm or suicide when asked directly about this and his behaviour and demeanour gave no indications otherwise. We are satisfied that he gave no sign to staff that he was contemplating taking his own life. While his illness and circumstances meant he was always at increased risk of suicide and self-harm there was no indication that he was at particular risk at the time which would have indicated an ACCT should have been opened.

62. However, given the man's range of risk factors we are surprised that an ACCT document was not opened when he was first recalled to prison. Being recalled in itself heightens risk. For at least the early weeks, monitoring under an ACCT would have allowed the effect of his return to prison to be assessed. People suffering from schizophrenia are at very much greater risk of suicide than the general population and, combined with the man's other risk factors this should have been considered. There is little indication that these factors were taken into account and staff seem to have relied too much on subjective assessments of the man's personal presentation. When he first returned to Northumberland there seemed to be a potentially dangerous reliance on healthcare staff's previous knowledge of him rather than an objective reassessment of his risk. On the evidence available, greater weight should have been given to the man's known static risk factors. We therefore make the following recommendation:

The Governors of HMP Durham and HMP Northumberland should ensure that all the known risk factors of a recalled prisoner are fully considered when assessing the risk of suicide and self-harm.

Clinical Care

63. The man was appropriately referred to the mental health team regarding his mental heath history when he came into prison. He had well documented and extensive interventions with a member of the mental health team and the visiting psychiatrist throughout his time in custody.

64. The clinical reviewer concludes, :

> "The man was a gentleman with mental health problems who received a good standard of health care whilst at HMP Northumberland. His care was equitable to that which he could have expected in the community.
>
> "There were good practices in place by referrals from the primary care team to in reach if a client went sick or RIC (rest in cell) for the day."

65. The clinical reviewer finds that the clinical interventions were appropriate and well documented and makes no recommendations. We agree with the clinical review.

Allegations of bullying

66. After the man's death, prisoners gave staff information which alleged that he had been bullied by three prisoners. The investigator checked the security and wing records of each of the prisoners allegedly involved. There was no previous information about the man being bullied and the only information about him possibly being intimidated by other prisoners was received after his death.

67. Sometimes prisoners try to persuade doctors to prescribe medications that they can then trade on the wing or use to pay debts. These would include some sleeping tablets. The man had regular reviews with mental health staff over two periods in custody, and it was their view that his symptoms were genuine and he needed medication to aid his sleep on occasion. There is no evidence he sought them for other reasons.

68. Once alerted to the allegations after the man's death, prison staff investigated and followed the Anti-Social and Unacceptable Behaviour Strategy by putting in place a monitoring programme and moving one of the alleged perpetrators to the segregation unit.

69. From the evidence gathered during the investigation, we consider it was possible that the man had got into some trouble with debts for tobacco but we have been unable to establish any firm evidence that this was the case and whether it was part of the factors which led to his death.

Emergency response

70. Use of an emergency code enables those attending to be better prepared for the type of situation they are attending and inform what emergency equipment might be needed. Effective code systems highlight the nature of the emergency and allow the communications officer to call an ambulance immediately if a particular code is used. Although it was apparent there was an emergency situation as soon as the man was found an ambulance was not called until 10.52am, approximately ten minutes after the Code Blue had been called. This delay could have been avoided had the call been made as soon as the Code Blue was heard. We make the following recommendation:

    The Governor should ensure an effective code system is implemented, which includes a requirement to phone for an ambulance immediately in appropriate emergency situations.

71. The initial staff response to the emergency was swift, but once the man was cut down he was not placed flat to aid any recovery or resuscitation attempt. This would have been in line Prison Service Order 1400, Incident Management. The clinical reviewer comments:

> “There was a slight delay as his cell door was blocked by him sat slumped behind the door as the officer who cut the ligature stated he could not hold his weight so let him slump down until assistance arrived.
>
> “If the man had been placed in the middle of the cell it would have given better access to begin resuscitation.”

72. Nurses started CPR and the AED was attached, but as there was no cardiac rhythm there were no instructions to shock the man during the CPR. The clinical reviewer indicated that all the nurses had annual training in emergency care management and we are satisfied that their response was appropriate. The nurses continued CPR until the paramedics arrived and took over the man’s care. Following their assessment and treatment, the prison doctor confirmed that he had died.

73. The officers on the wing made no attempt to begin CPR before the nurses arrived. Two of the officers were not first aid trained and the acting senior officer, who was first aid trained was unfortunately unable to deal with the situation because of trauma from a previous incident. This meant that the man was left in the cell for at least six minutes before an attempt at resuscitation began. We cannot know whether it would have been possible to resuscitate the man when he was first found, but this was an unacceptable delay. The prison records show that on the 18 June out of 202 uniformed staff on duty only 29 were first aid trained. On Houseblock 7, where the man lived, the prison’s family liaison officer was the only member of staff on duty who was first aid trained. The response to finding the man’s hanging indicates that this was insufficient to provide an appropriate emergency response. We make the following recommendation:

    The Governor should ensure there are sufficient members of first aid trained staff on duty in each part of the prison at all times to provide effective emergency response.

Actions following a death in custody

74. Prison Service Instruction (PSI) 64/2011 ‘Management of prisoners at risk of harm to self, to others and from others (Safer Custody)’ details the mandatory actions required to be undertaken by staff following a death in custody. The PSI specifically it states:

> *“Staff directly involved in the incident, particularly those who were first on scene, must complete Incident Report Forms as soon as is practicable.”*
>
> *“In line with PSI 08/2010 Post Incident Care a ‘Hot Debrief’ must be held immediately after the all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including Healthcare staff, should be invited. It may be useful to keep a record of those who attend.”*

75. Following the man's death no hot debrief took place and the staff involved in the emergency incident were not asked to complete an incident report form. We make the following recommendation:

    The Governor should ensure that a hot debrief is held after a death in custody and that staff complete incident report forms.

CONCLUSION

76. The man had a history of mental illness and he was prescribed anti-psychotic and anti-depressant medication. The man had regular interventions with the mental health team and the visiting psychiatrist. The man was regularly assessed for the risk of suicide or self-harm and he consistently said he had no such thoughts. While he had a number of factors which made him a very high risk of suicide and self-harm, he was not managed or monitored under ACCT procedures. We think this should have been fully considered when the man was recalled to prison. However, despite the high risk, we do not think that staff could have foreseen the man's actions some months after his return.

77. We consider that appropriate assessments were made of the man's physical and mental heath needs and the standard of clinical care he received at HMP Northumberland was equivalent to that he could have expected to receive in the community.

78. Although there were allegations after the man's death that he had been the victim of bulling we were unable to find sufficient evidence to substantiate this.

79. When the man was found hanging, there was too much of a delay in starting CPR, and in calling an ambulance.

RECOMMENDATIONS

1. The Governors of HMP Durham and HMP Northumberland should ensure that all the known risk factors of a recalled prisoner are fully considered when assessing the risk of suicide and self-harm.

   Accepted

   Induction staff and HCC staff will be briefed on potential risk factors to look for when conducting the induction process in reception.

   QTL bulletin will be published in a Staff Information Notice for all staff to consult.

2. The Governor should ensure an effective code system is implemented, which includes a requirement to phone for an ambulance immediately in appropriate emergency situations.

   Accepted
   The current system for requesting an ambulance will be reviewed by the HCC department and the Operations managers. Any changes will be cascaded to all managers and supported by a Staff Information Notice.

   Communication room trained staff will be made aware of their current responsibilities for requesting an ambulance in an emergency situation.

3. The Governor should ensure there are sufficient members of first aid trained staff on duty in each part of the prison at all times to provide effective emergency response.

   Accepted
   The current list of 'First Aid' trained staff will be reviewed.

   The Health and Safety department will monitor the number of staff trained as 'First Aiders' and ensure the figure is maintained at the level required

4. The Governor should ensure that a hot debrief is held after a death in custody and that staff complete incident report forms.

   Accepted
   The importance of conducting a 'Hot De-brief' after each DIC will be reiterated to all managers by way of the SMT meetings and daily managers meetings.

   The Safer Custody/FLO department will raise this as an agenda item in Safer Custody meetings so it can be monitored and quality checked.