Investigation into the circumstances surrounding the death of a man at HMP & YOI Hull in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the circumstances of the death of a man who was found hanging in his cell in HMP Hull in May 2011. He was 45 years old. I extend my sincere condolences to his family and friends for their loss. I apologise for the delay in issuing this report.

This investigation was undertaken by one of my senior investigators. A review of the man's clinical care was carried out by a clinical reviewer on behalf of the local Primary Care Trust.

This was the man's first time in prison custody and he had been in Hull for only three days by the time of his death.

During his time at Hull, the man received additional support and monitoring by staff as he was recognised to be at risk of harming himself. Unfortunately, one of the key components of the support plan broke down and he was left as the sole occupant of a cell when he should have been with a cell-mate.

Unlike some deaths investigated by my office, the lack of swift identification of a person at risk was not the issue here. Staff realised that the man was at risk of harming himself and developed protective measures for him. However, these centred around him having a cellmate and, once this part of the system failed, it left him vulnerable. Close consideration in the report is given to the weaknesses in the suicide prevention measures used, what more staff might have done and what improvements are required. Associated recommendations are made to mitigate such failings in future.

Another point raised in this report, and also in a previous investigation into a death at Hull, concerns speedy access to the emergency services. Although it was clear that an ambulance was required when the man was found, it took too long for it to be requested. This is at odds with the service's policy that internal processes should not obstruct what can be a life saving telephone call and it is important that this is rectified.

This 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 **July 2012**

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SUMMARY

1. The man was 45 years old. He was found hanging in his cell at HMP Hull in May 2011. This was his first time in prison custody.

2. The man arrived in Hull in the late afternoon of 6 May. He was a remand prisoner, charged but not convicted of assaulting his wife. He told staff that he had recently attempted suicide and had thoughts of self-harm or suicide. Staff opened an ACCT[1] plan and noted that he should be located in a shared cell to provide him with further support. He made similar comments about having current thoughts of self-harm or suicide when he was assessed by a reception nurse that evening. He also reported to the nurse that he felt depressed. Following his assessment with the reception nurse, he was located in a shared cell on A wing (the reception wing).

3. During an ACCT assessment interview and ACCT case review the following day, the man repeated that he felt depressed. When asked whether he intended to harm himself, he said that he was unsure whether he would do so or not.

4. After spending two days on A wing, the man was transferred to H wing where he was again located in a shared cell.

5. On the morning of 9 May, the man's cell-mate was transferred to a different prison. Staff were aware that his ACCT plan included the decision that he should placed with a cell-mate. The officer responsible for prisoner movements had hoped to find a suitable person for him to share with, but had not found him a new cell-mate when his shift ended that evening.

6. The man's ACCT plan also required that he should be checked at hourly intervals at night-time. At approximately 10.00pm that night, an officer looked into his cell and saw him hanging from a ligature that had been attached to his bunk-bed. Staff went into the cell, cut the ligature and attempted resuscitation. Ambulance paramedics also attempted to resuscitate him. Unfortunately all their attempts proved unsuccessful and he was pronounced dead at 10.30pm.

7. This report makes seven recommendations. Four concern aspects of the ACCT process. Two recommendations are about summoning of the emergency services. Another recommendation concerns provision of out-of-hours medical services. The final recommendation is about a disciplinary investigation.

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[1] ACCT (Assessment, Care in Custody and Teamwork) is the process used for monitoring and supporting prisoners deemed at risk of self-harm or suicide. A fuller explanation is given on page 6.

THE INVESTIGATION PROCESS

8. A senior investigator was appointed to this case. He first visited HMP Hull on 16 May 2011, when he met two of the prison's functional governors, a representative from the Prison Officers' Association and a member of the Independent Monitoring Board. (Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community to help ensure that standards of decency and care are maintained. Members of the Board have access to every part of the prison and all prisoners held there.)

9. The investigator visited the man's cell and was shown around the wing. He was given a copy of the man's prison and health records. Notices were issued to staff and prisoners informing them of the investigation and inviting them to contact the investigator if they wished to be involved in the investigation. No one came forward in response to the notices about the death.

10. The investigator subsequently interviewed 12 members of staff and two prisoners.

11. The investigator contacted the Coroner's officer and a copy of this report will be sent to the Coroner to assist his enquiries.

12. A clinical reviewer carried out a review of the man's clinical care and treatment on behalf of the local Primary Care Trust.

13. One of the Ombudsman's family liaison officers contacted the man's wife to inform her of the investigation and to offer the opportunity to raise any questions or concerns. The family liaison officer and investigator visited her. She questioned why her husband had been left in a cell alone, and asked why he had been allowed a television given that he could have used the electric lead as a ligature. She questioned how her husband had managed to tie his wrists and ankles and also pointed out that she had not observed any ligature marks on his neck. She also questioned whether her husband had received his prescribed medication while in prison. She raised a number of other issues that fell outside this office's remit and so were dealt with outside of this report.

14. The delay in the publication of this report was caused by workload pressures in the office.

HMP Hull

15. HMP Hull is a Victorian prison close to the city centre. Hull is a local prison holding remand, sentenced and convicted adult males and young offenders. The operational capacity is just over 1,000.

Her Majesty's Chief Inspector of Prisons

16. Her Majesty's Chief Inspector of Prisons' (HMCIP) last inspection of Hull before the man's death was an announced inspection in November 2008. In her introduction, the then Chief Inspector wrote:

> "Hull is a large local prison on an extensive site, holding a mixed population of mainstream adult prisoners, young adults and vulnerable prisoners. It is extremely credible that, even with current population pressures, this inspection showed that it was performing reasonably well across all our key tests – safety, respect, purposeful activity and resettlement.
>
> "Overall, Hull was achieving some good outcomes for a local prison, particularly in activities and resettlement … The area of most concern was safety, where attention was needed to the basics of safer custody, as well as the development of innovative approaches. With that proviso, it was easy to see Hull becoming a high-performing local prison."

Assessment, Care in Custody and Teamwork (ACCT)

17. ACCT is the prison service process for supporting and monitoring prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner is at risk. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision (where staff must check the prisoner) and interactions (where staff must have a meaningful conversation with the prisoner) are flexible and can be set according to the perceived risk of self-harm. If staff believe the level of risk to be very high, the prisoner may be constantly supervised, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of supervision may be several times an hour or day. Supervision will also take place during the night. As part of the process a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings. Wherever possible, the prisoner at risk is also included in review meetings.

Previous deaths at Hull

18. There have been two other apparently self-inflicted deaths at Hull in the four years leading up to the man's death. In the most recent of those cases, a recommendation was made about the need for an ambulance to be summoned promptly in the case of an emergency. That recommendation is repeated in this report.

KEY EVENTS

19. The man was born in Bangladesh in 1965. He later moved to England and settled in Scunthorpe in North Lincolnshire. He was married and had four children.

20. On Friday 6 May 2011, the man was remanded into HMP Hull charged with several counts of assault causing actual bodily harm. The victims were his family. This was his first time in prison custody. He arrived in Hull in the late afternoon. Upon reception, he was seen by an officer. The documents accompanying him included a person escort record (PER). This is a document used when prisoners are escorted to and from court and from one place of custody to another. The PER is completed with risk factors known about the prisoner. The man's PER form contained brief reference to the offences with which he had been charged and included a note to say that he had told a police official that he would kill himself "upon release from custody".

21. During an interview with the investigator, the reception officer said that the man appeared nervous and worried about what would happen. The officer asked the man about the entry on the PER form. He said that he could not actually remember the assault, but he was very embarrassed and upset about what he had apparently done. The officer asked him whether he intended to harm himself and his reply indicated that he was unsure whether he would or would not. He also mentioned that he had recently attempted to take his life. In response to this information, the officer opened an ACCT plan. Once the officer had completed all of his actions, the man was taken to A wing where he was placed in a waiting room ahead of being seen by a reception nurse. (A wing is Hull's induction wing. Prisoners usually remain on A wing for their first 24 to 48 hours while receiving information about how the prison works and what is likely to happen to next. They also receive help and advice on social and other issues.)

22. The investigator spoke with a prisoner who worked as an Insider[2] and as a Listener[3]. As part of his Insider role, he spoke with the new prisoners that evening. He said that when he looked into the waiting room, the man stood out from the other prisoners. The other prisoners were chatting among themselves but the man appeared to be a "typical first time prisoner" as well as appearing to be "in a state". The prisoner said that he took the man to a quiet room and explained the support that Listeners can provide to other prisoners. The man spoke about his life. He said that he had a business, which he had lost. He said that he had a family, but had harmed his wife and he feared he would lose contact with his children. The prisoner said that the man started crying and said that he would take his life. The prisoner told the man that he would be able to see his children again and that he should speak with a solicitor about this. The prisoner told the investigator that his conversation with the man went

[2] Insiders are prisoners who speak to newly arrived prisoners to inform them about life in prison, including the daily routine.

[3] Listeners are prisoners trained by the Samaritans to provide the same service as Samaritans offer in the community. The service is available 24 hours a day and a rota system is used to meet this aim.

on for around 20 minutes and the man started to ask questions about the prison. He asked if he would be locked in his cell all day and the prisoner told him that would not be the case and that it was possible that he would be able to get himself a prison job. The prisoner asked the man's permission to tell the nurse about his comment about taking his life. The man agreed, so the prisoner passed on this information.

23. The investigator and clinical reviewer interviewed a nurse who worked on A wing that evening carrying out health assessments for new prisoners. (All prisoners receive a reception health assessment on entering prison. The aim of this assessment is to identify any needs or health concerns that the prisoner might have. It includes establishing the person's physical and mental health history.) The man was with the prisoner Insider/Listener when she called him for his healthcare assessment. She said that at this point the two prisoners had just finished speaking and they were smiling and shaking hands.

24. The nurse said that at the healthcare assessment, the man confirmed that he had a history of depression and had taken an overdose in the past (two months previously) and had thoughts of self-harm or suicide. He reported that he had been prescribed fluoxetine (for depression) and simvastatin (for reducing cholesterol) in the community. She told the investigator that, while the man interacted well during the assessment, she noted that he seemed "very low mentally". She explained to the investigator that she did not consider his mood to be so low that he needed to be transferred to the prison healthcare unit. She told him that she would refer him to the mental health team and he agreed to that. She made an entry in his ACCT plan to confirm this referral. She explained to the investigators that the mental health team did not work at the weekend so he would not be seen until the following week.

25. The nurse also made a referral to a prison doctor for the man to be re-prescribed his community medications. However, as with the referral to the mental health team, he would not be seen over the weekend and would have to wait until the following week.

26. The ACCT process includes the implementation of an 'immediate action plan'. The purpose of this plan is to keep the prisoner safe pending further consideration, within the following 24 hours, of their level of risk and ongoing needs. The man's immediate action plan included the need for him to be placed in a shared cell to give him the support of a cell-mate. (Cell-sharing is a known protective factor against suicide. The companionship cell-sharing offers can help to reduce feelings of loneliness, and a cell-mate will be able to alert staff or a Listener if they are particularly worried about their companion. Past studies have found that around 65 per cent of self-inflicted deaths occurred in single cells.)

27. Ongoing support under ACCT is provided through 'conversations' (which should be meaningful) and 'observations' (usually a brief check that the person is well). In the man's case, his ACCT plan required that staff should make three "meaningful" entries in the plan during the day (meaning three conversations), with hourly observations to be made through the night. Following this, he was

placed in a shared cell. An entry in his ACCT plan at 8.40pm noted that he was talking with his cell-mate at that time.

28. A landing officer on A wing told the investigator that he introduced himself to the man when he unlocked his cell on the morning of 7 May. He asked the man how he was settling and he replied that he had not slept and was feeling "down". He said that he had spoken to a Listener the previous evening and would like to see the Listener again. The officer made arrangements for this. He told the investigator that the man's demeanour seemed much the same as any other person in prison for the first time.

29. The Listener told the investigator that he, and another Listener, spoke with the man for around half an hour that morning. The man made a comment that indicated he was considering harming himself and the Listener asked his permission to pass this information to an officer. The man refused to permit this[4]. He asked if he would always be able to see him if he needed a Listener. The Listener told him that he would be seen by whichever of the Listeners was on the duty rota.

30. The same landing officer made an entry in the man's ACCT plan shortly after he had seen the Listener:

> "States he feels better for having spoken to the wing Listeners but he is still very low in mood. Cannot guarantee not self harming."

31. The ACCT process includes a detailed assessment interview to be carried out within 24 hours of the ACCT plan being opened. The assessment includes an exploration of factors such as the problems leading to the risk, details of recent acts of self-harm, the person's mental health state and any present thoughts of self-harm or suicide. An officer met the man for an ACCT assessment interview at around 11.00am on 7 May.

32. The officer told the investigator that the man said very little during the assessment interview. He mentioned that he had a history of mental health problems and that he currently felt depressed. He also said that he had a history of acts of self-harm and he did not know whether he would harm himself again in the future. The man briefly mentioned the offence with which he had been charged and said that "he had no family to go home to". The officer told the investigator that he tried to encourage the man, but nothing he said seemed to help. He estimated that the interview lasted a little over 15 minutes and the man was much the same at the end as he had been at the beginning. Given his mental health history, the officer completed an urgent referral to the mental health team. He told the investigator that it would usually take "a couple of days" for a prisoner to be seen by the mental health team following a referral. As the assessment was reaching its conclusion, a Senior Officer came into the room to chair an ACCT case review. (A case review, chaired by the unit manager, is the next stage of the ACCT process following an assessment

[4] Listeners are bound by rules of confidentiality and cannot generally pass on information shared with them without that agreement of the client.

interview. The case review should ideally be held immediately after the assessment interview and must in any event be held within 24 hours of the ACCT plan being opened.)

33. A Senior Officer (SO) from A wing told the investigator that his usual practice was to allow the ACCT assessor around 15 to 20 minutes with a prisoner and to then join the meeting as the assessment ends. The SO said that the officer summarised what he and the man had discussed and he read what the officer had written. He agreed with the officer‘s plan to refer him to the mental health team. The SO said that, as it was the weekend, it would be the following week before the mental health assessment took place. The referral to the mental health team was entered into the CAREMAP. (The CAREMAP is used to identify the person’s most urgent and pressing issues with the action to be taken to deal with those problems.) The reference in the immediate action plan to him needing the support of a cell-mate was not included in his CAREMAP. Even so, all of the staff who dealt with the man understood that having a cell-mate was a central aspect of his care.

34. The level of support set for the man the previous evening had been three meaningful conversations during the day with hourly observations through the night. The review panel left this unchanged and planned the next ACCT review to take place seven days later. The investigator asked the SO whether some of the man’s comments, such as being unsure whether he might harm himself and having no family to go home to due to his index offence, meant that the number of conversations and observations should have been set at a higher frequency. The SO said that he thought the frequency set was appropriate. He did not think that the man was very much different to others in prison for the first time. He also pointed out that the man was in a shared cell and seemed to be getting along with his cell-mate.

35. The Listener told the investigator that he spoke briefly with the man at 2.00pm that day and he thought his mood had lifted since the morning. He asked him if he wanted to speak with him again as a Listener and the man answered that he did not.

36. Prisoners remain on the induction wing for between 24 and 48 hours, after which they are moved to one of the other wings. The man moved to H wing after lunch on 8 May. His cell-mate told the investigator that he and the man had got along well together. The man had spoken about his family and about having run his own business. He said, though, that he had started gambling and had “lost everything”. He said that he hoped his family would forgive him, in which case everything would be “fine”. But if they did not forgive him, it would be “the end”. When they each moved to H wing, they went to different cells. The man said that he wanted a single cell as he prayed five times a day and did not want to disturb a cell-mate through doing this.

37. The man moved to H wing after lunch on Sunday 8 May and was allocated to a shared cell (cell H3-11). At some point he was moved to a single cell, but in the early evening staff noticed that his ACCT plan included that he should be in a shared cell, so he was moved back to his previous cell. His new cell-mate told

the investigator that he spent his time watching television and did not have any conversation with the man.

38. Another SO told the investigator that, although she normally worked on B wing, she worked on H wing on Sunday 8 May. She helped with the serving of the evening meal when the man spoke with an officer to ask if he could move to a single cell. He explained that he was spending a lot of time at prayer. The officer told the man that he would have to remain in a shared cell for the time being as he had only just arrived in prison and was still being monitored through the ACCT process. He was told that staff would consider moving him to a single cell once he had settled. He thanked the officer.

39. An officer told the investigator that he usually worked on C wing, but worked on H wing on 9 May to cover staff shortages. At just after 8.00am that morning he unlocked cell H3-11 to tell the man's cell-mate that he was being transferred to a different prison. The officer wrote in the man's ACCT plan to say that he was sat on his bed at that point and he indicated that he felt okay.

40. One of Hull's nurses contacted the man's general practitioner in the community to confirm details of the medications he was prescribed. It was confirmed that one of his prescribed medicines was an anti-depressant (fluoxetine).

41. There were still some aspects of the prison induction process that the man still needed to complete and he went to A wing that morning to finish these. An officer told the investigator that he spoke with the man several times while the induction continued. He said that there was nothing about the man's demeanour to cause concern. The officer added, though, that he was still "keeping himself to himself". He said staff believed this was because he was still settling, in contrast to prisoners who had been in Hull before and who therefore knew one another. The man returned to H wing at lunch time.

42. An officer told the investigator about a conversation that he had with the man at around 3.30pm that afternoon. The officer was checking cells for any damage and when he reached the man's cell he asked him how he was. The man said that he was okay and the officer asked him if he had any medications to collect from the nurses. He said that his medication had been taken from him at reception and he was still waiting for it to be re-prescribed. He added, though, that he had an appointment with a prison doctor for the following day (Tuesday). The officer asked the man why he was in custody, but he only gave brief details. He went on to mention, though, that he was due back in court on the following Friday and he asked what would happen. The officer told him that he would be woken early in the morning to get ready for court and he advised him to speak with a solicitor about legal issues such as the process for seeking bail. The officer told the investigator that he then had to go to help deal with other prisoners so his conversation with the man came to a close. The officer thought that the man seemed quite positive; citing the fact that he was thinking of the future by reference to his medical appointment the following day and his court appearance at the end of the week.

43. The same officer saw the man once more that afternoon. This was at around 4.15pm when prisoners are locked in their cells and a role check completed. He thought the man was lying on his bed. He signed the role form to confirm the number of prisoners he had counted and at 4.45pm his shift ended.

44. The investigator asked the officer about the man being left as the sole occupant of cell H3-11 following his cell-mate's transfer. The officer knew that the ACCT plan included that the man should have the support of a cell-mate. He said that he was sure that he had told the movements officer[5] about the man losing his cell-mate and he assumed the matter would be dealt with.

45. During a telephone interview with the investigator, the movements officer said that he knew the man's ACCT plan spoke of him needing the support of a cell-mate. He said that the man had asked him that day if he could move to a single cell as he prayed five times a day and this disturbed his cell-mate. The officer told him that he would have to remain in a shared cell while the ACCT plan remained open. He added, though, that he would try to find another Muslim prisoner for him to share with.

46. The movements officer agreed that an officer had informed him that the man's cell-mate had been transferred leaving him as the sole occupant of a cell. He added, though, that the officer made the remark as a general observation as all the staff, including the senior officer, were already aware of the situation.

47. The movements officer said that he had hoped to find the man a new cell-mate, but he found it difficult to find a suitable person for the man to share with. In addition to the time he was spending at prayer, the man could not be paired with a prisoner with racist views and, as a non-smoker, could not be paired with a smoker. The movements officer said that he checked if any of the safer cells[6] were available, but none were. His shift finished at 7.30pm, but even at that stage in the day it was possible that a suitable person might have transferred on to the wing. He said that he would have had a handover discussion with the oncoming evening staff, although he could not recall who that person had been.

48. The movements officer told the investigator that he could not recall speaking with the SO before he went off duty, but said that he would have done had she been on the wing at the time. He added that it was the senior officer's responsibility to know what was happening on the wing before the end of their shift.

49. The SO told the investigator that she did not ordinarily work on H wing, but worked on that wing on 9 May as cover for staff absences. She said that when she initially arrived on the wing she checked all of the open ACCT plans to check whether any of the prisoners were due for a case review. She thought that there were around eight open ACCT plans on the wing that day so she

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[5] Each day one of the wing officers acts as the movements officer with responsibility for arranging prisoner moves around the prison.

[6] A safer cell is one designed to minimise the number of ligature points and other possibilities of a self-harm.

could not recall the man's ACCT plan in particular. Nor could she recall ever meeting the man.

50. The SO said that prisoners on open ACCT plans were usually placed with a cell-mate and, where they lost their cell-mate through a transfer, they would usually be found a new person to share with. Her view was that responsibility for ensuring that this happened was a shared one between the landing officer and the movements officer. She explained that landing officers receive a list each morning of prisoners being transferred out, so they will be aware of those prisoners on open ACCT plans who will need to be found a new cell-mate. In addition, the movements officer should also be aware of any prisoner movements that might impact upon prisoners on open ACCT plans. She confirmed that she was never informed that the man had lost his cell-mate and she stressed that she would have dealt with the problem had she been informed.

51. An officer who worked the night shift told the investigator that this was his first day of work following a period of leave so he had no prior knowledge of the man. He said that he arrived on the wing at just after 7.30pm and checked which of the prisoners were on open ACCT plans. He then counted the prisoners on each landing and, while doing so, checked the prisoners on ACCT. When he reached cell H3-11, the man was just in the process of kneeling down to pray. The officer said that staff avoid disturbing Muslim prisoners when at prayer, so he continued with his other checks. He made a note in the ACCT plan about this observation, which he timed at 8.16pm. He checked him again at just before 9.15pm. At that time the man was sitting on his bed.

52. At 10.00pm, the officer began his next set of ACCT checks. When he checked cell H3-11, he saw that the man was hanging from a ligature that was attached to the bed frame. He ran to call for assistance from another officer, who was nearby, and he also radioed for a response from medical emergency staff and the Night Orderly Officer (NOO)[7]. At night time, cell keys are carried in sealed pouches to be opened only in the case of an emergency. The officer told the investigator that he had trouble breaking the seal for the security pouch and had to bite off the seal. Having done that, he unlocked the door and he and the other officer went into the cell and cut the ligature. The officers found that the man had tied his wrists and ankles together and was in a cross-legged position. The officers had to cut the wrist and ankle ties so they could lay the man properly onto the floor. The NOO had arrived by this point.

53. The NOO told the investigator that she arrived within around two minutes of being informed of the emergency. She asked the officer to try to find the drug treatments nurse. She said that G wing, which adjoined H wing, was for prisoners with drug problems and a drug treatment nurse would sometimes be on duty on that wing during the night[8]. She commenced giving chest compressions. She said that the man's tongue was very swollen so she was

[7] The Night Orderly Officer is the person in operational charge of a prison at night time. The NOO carries the radio call sign Oscar 1.
[8] The Nurse was the drug treatment nurse on duty that night.

unable to give mouth-to-mouth breathing. One of the officers brought an emergency medical bag to the cell, however, and she was able to use an ambu-bag[9] to hand pump air into him.

54. During an interview with the investigator and clinical reviewer, the nurse explained that he worked as an in-patient nurse in Hull's healthcare unit and was the first response[10] nurse that particular night. He said that the healthcare unit is a self-contained unit separate to the main prison. For security reasons, nurses do not carry keys at night that unlock the main gates in and out of healthcare. If the first response nurse is needed for an emergency at night, they must be collected from healthcare by the NOO or the assistant NOO as they are the only staff with keys for the main gates.

55. The nurse said that he heard the emergency call on the radio. He tried to obtain clarity about whether it was a code blue alarm (for a prisoner with breathing difficulties) or a code red (for bleeding). However, he was only told that he was needed urgently and an officer (the assistant NOO) was on the way to healthcare. He collected the large emergency bag. (This contains more medical equipment than the smaller emergency bags stored on the prison wings.) When the assistant NOO arrived, he and the nurse went quickly to H wing. The nurse said that on arrival, he checked the man for signs of breathing and presence of a pulse and then began giving oxygen. The drug treatment nurse arrived and gave chest compressions. After the first standard set of 30 compressions, the nurse took over and provided further sets. They checked the man with a defibrillator[11] at intervals, but the advice each time was that no shock should be given and that attempts at artificial resuscitation (CPR – cardio pulmonary resuscitation) should continue.

56. The NOO asked the control room to summon an emergency ambulance. The control room records show that the emergency call was made at 10.14pm and that the ambulance and paramedics arrived at 10.20pm. They paramedics took over the efforts to try to resuscitate the man. After ten minutes they ceased their efforts as it was clear that he had died.

Liaison with the man's family

57. Hull's governing Governor came into the prison after being contacted at home and told about the man's death. Staff at Hull were aware of the circumstances surrounding his index offence and were aware that his wife was still in hospital. However, staff were able to find details of the man's brother-in-law and discovered that he lived locally. At 1.00am, the Governor, in company with one of Hull's functional governors, visited to break the news. The brother-in-law told the staff that he would tell his sister and would also inform the man's other

[9] An ambu-bag comprises a mask connected to tubing that allows air to be hand pumped into a patient.

[10] The first response nurse is the nurse responsible for responding to medical emergencies.

[11] A defibrillator measures electrical activity in the heart and gives audible instructions on management of the patient such as whether or not an electrical shock should be given.

relatives (who lived in London). Staff had left telephone contact numbers for the prison and through the night a number of relatives telephoned asking for information.

58. Staff from Hull subsequently visited the man's wife to give details about the circumstances surrounding her husband's death. They also informed her that assistance was available for the funeral expenses. Staff also visited his other relatives in London to answer their questions.

Support for prisoners

59. Prisoners were told about the man's death and the Samaritans were also notified so they could provide additional support as needed. Checks were made on other prisoners in Hull who were being supported through ACCT processes.

Support for staff

60. A hot debrief meeting with staff was conducted by a governor to consider possible learning arising from the man's death. Staff were told about support available to them through the care team.

ISSUES

The assessment of the man's level of risk and the frequency of conversations and observations

61. When the man arrived into Hull he reported a recent suicide attempt. He also reported current feelings of depression and could not say whether or not he would attempt to harm himself again. In response, staff opened an ACCT plan. Staff were to have three quality interactions with him during the day and he was to be observed on an hourly basis through the night. He was also to be supported through being placed with a cell-mate (a known protective factor against suicide). The decision to locate him on a shared cell was a proactive and appropriate decision.

62. Guidance and instruction on suicide and self-harm prevention and the ACCT process is contained in Prison Service Order (PSO) 2700 (Suicide prevention and self-harm management). The PSO acknowledges that early days in custody and imprisonment on remand are times of high risk of suicide and self-harm for the majority of prisoners. In regard to ACCT, the PSO explains that the frequency of conversations and observations must be appropriate to the individual's assessed level of risk, including their perceived intent and individual need. However, the PSO gives no specific guidance, or examples of situations, where a particular level of conversations and observations might be applicable. The reason for this is that staff are expected to deal with prisoners as individuals so individual support plans should be tailored to the individual and to their individual set of circumstances.

63. Deciding on the appropriate frequency of conversations and observation in the man's case was therefore very much a matter for the personal judgement of the staff dealing with him. The frequency of conversations and observations had been set on the evening of 6 May and were open for review following the case review that took place the following morning. An SO chaired that review and his evidence to the investigator was that the frequency set for the man seemed appropriate. He thought that he was not dissimilar to many others being supported through ACCT. In addition, he was in a shared cell and was getting on with his cell-mate.

64. As previously stated, cell sharing is a known protective factor against suicide. That said, PSO 2700 makes it clear that the cell-mate bears no responsibility for keeping safe the at-risk prisoner. That always remains a staff responsibility. It should be borne in mind too, that there will be periods in the day when the at-risk prisoner is liable to be left alone in his cell: for instance the cell-mate might choose to go to exercise while the at-risk prisoner declines that opportunity.

65. While acknowledging that it is for staff to judge an appropriate level of conversations and observations, it would seem that staff might have overly relied upon the use of a cell-mate. PSO 2700 makes it clear that:

    > "It is the responsibility of staff - not cellmates or other prisoners - to keep prisoners safe. Cell-sharing or use of Listeners (or other peer

supporters) must not be used as an alternative to staff interaction with an at-risk prisoner, including for conversations or observations."

66. It is possible that staff were also swayed by the way the man presented himself during the ACCT assessment and review. The man had a number of risk factors that put him at raised risk of suicide or self-harm. He had recently attempted suicide, he had feelings of depression and uncertainty over whether or not he would attempt to harm himself again. In addition, this was his first time in prison custody, and he was on remand having been charged with serious offences against family members. On balance, the frequency of conversations and observations would seem too low. Cell-mates are often absent from the cell due to exercise, visits and work and relying on a cell-mate rather than formal ACCT processes left him vulnerable in his early days in prison. Instead, it would have been prudent to have set the conversations and observations at a higher level during these initial days in custody.

The Governor should ensure that the frequency of ACCT conversations and observations take into account all relevant risk factors

The Governor should ensure that the setting of ACCT conversations and observations is not unduly influenced by whether the prisoner has a cell-mate

The man's lack of cell-mate

67. As mentioned, an intrinsic aspect of the man's support plan was to place him with a cell-mate. Having spent two nights on A wing, he moved to H wing on 8 May where he was placed in another shared cell, but with a different cell-mate. He was re-allocated to a single cell for a short period that afternoon. However, staff realised that he needed to be in a shared cell and he was moved back to the previous one.

68. On the morning of 9 May, the man's cell-mate was transferred to a different prison which left the man as the sole occupant of cell H3-11. The movements officer that day and the officer responsible for the third landing both realised that the man needed a new cell-mate and the landing officer made a point of reminding the movements officer.

69. The movements officer's evidence was that there were no safer cells available so he had hoped through the day to find a suitable person for the man to share with. However, he experienced some difficulty in finding a suitable person and had not identified a cell-mate by 7.30pm when his shift ended. He said it was still possible that a suitable person might be transferred onto the wing after this time. He could not recall speaking to the senior officer before he went off duty, but said that it was her responsibility to know what happened on the wing.

70. The SO's evidence was that she had checked all of the ACCT plans on H wing on the morning of 9 May, although she could not recall meeting the man. She said she was not informed that he had lost his cell-mate and said that she would have taken action had she been informed.

71. It is disappointing that the movements officer did not consider it necessary to have found the man a cell-mate before the end of his shift. Even if it were not possible to have found him the ideal cell-mate, a temporary solution would have been better than to have left him alone. Neither of the two prisoners with whom he had previously shared with during his brief time in Hull were Muslims, but neither seemed to object to the amount of time he spent at prayer. Indeed, it was clear to the investigator that his first cell-mate enjoyed his company.

72. PSO 2700 recognises that failures in communication are one of the commonest contributory factors found in investigations into self-inflicted deaths in prisons. It is thus even more disappointing that the movements officer did not consider it essential to inform the SO before going off duty that he had been unable to find a new cell-mate for the man.

73. Even if it were the case that it was impossible to find a suitable person to share with the man, other options were available to try to keep him safe during the day and overnight. One option would have been to increase his observations pending a review of the position the following day. Another option would have been to review of those in safer accommodation and to risk assess whose need was greatest. Again, the lack of communication from the movements officer to the SO prevented this from happening.

74. The SO, as the wing manager, carried overall responsibility for what happened on the wing. However, she was dependent on support and good communication from her staff for her to discharge her functions properly.

    The Governor should conduct a disciplinary investigation into the actions of staff that led to the man being left alone in his cell without an alternative support plan

    The Governor should ensure that prisoners deemed to need support from a cell-mate are not left in a cell alone overnight, unless alternative protective measures are in place

Completion of CAREMAPs

75. The consideration that the man would benefit from having a cell-mate was noted in the immediate action plan of his ACCT document. The purpose of the immediate action plan is to consider and record the support needed to keep the person safe pending the first ACCT case review.

76. At the first case review, the review panel must draw up a CAREMAP if the ACCT plan is kept open. PSO 2700 states that CAREMAPs must reflect the individual needs and level of risk of the prisoner along with the core elements of their care such as company through cell sharing. (By definition, the immediate action plan is superseded upon production of the CAREMAP, although measures of support identified as part of the immediate action plan might well be included in the CAREMAP.)

77. When a CAREMAP was drawn up at the first ACCT review on 7 May, no entry was made about the man requiring the support of a cell-mate. Despite this omission, all staff with whom the investigator spoke were aware that this support was required. However, in future situations it is possible that important information could be missed if it is not transferred to the CAREMAP. Due to this, the following recommendation is made:

The Governor should ensure that CAREMAPS are completed in line with the requirements of PSO 2700

Summoning of the ambulance

78. The records made by Hull's control room staff indicate that around eight minutes elapsed between the emergency call and the request for an emergency ambulance. The ambulance was summoned on the instruction of the NOO.

79. A local protocol for summoning emergency ambulances, that was produced by East Hull PCT but ratified by HMP Hull, states that:

> "The decision for authorising an ambulance or paramedics to attend an incident can be made by any member of staff attending the scene: but the direct request to the Ambulance Service will be via Oscar 1 and the Control Room."

80. However, this instruction is at variance with an instruction issued in February 2011 by the Chief Executive Officer of the National Offender Management Service. He wrote then to all prison Governors on the matter of calling emergency ambulances saying:

> "It is … essential that internal procedures should not waste undue time in summoning emergency assistance … "

81. Moreover, the local protocol is inconsistent with Hull's local suicide and self-harm policy. This makes clear that any member of staff at the scene can authorise the attendance of an ambulance. The policy states that the call to the service must be made by the Control Room but, significantly, does not require the involvement of the NOO.

82. In the last self-inflicted death at Hull before that of the man, a ten minute delay occurred between the discovery of the death and the summoning of an ambulance. The recommendation from that case is repeated and a further recommendation added:

The Governor should ensure that staff request ambulances promptly as required in emergency situations

The Governor and PCT should revise the protocol on summoning emergency ambulances to align it with the instruction contained in the local suicide and self-harm policy and the Chief Executive of NOMS's letter of February 2011

The bindings to the man's wrists and ankles and absence of a ligature mark

83. When the man was discovered hanging, the officers found that he had tied his wrists and ankles together. His wife questioned how he had been able to do this unassisted. She also noticed, when washing her husband's body in accordance with Islamic tradition, that there was no ligature mark on his neck. The pathologist was asked to comment on these matters before finalising his report. The pathologist's comments included that:

> "… [the ligature had been] fashioned from a torn bed sheet. Another strip of bed sheet was tied around his legs, though the precise arrangement of the ligatures was not clear since they had been removed by prison staff.
>
> "I note … that a ligature had passed around his ankles. People attempting suicide do on occasion take measures to ensure they do not rescue themselves … Though in most suicides by hanging the ligature is only applied to the neck, binding of the hands or feet is not unheard of. The circumstances of this case, and in particular the witness evidence that he was seen locked in a single occupancy cell prior to the discovery of his body, mitigates very strongly against any third party involvement in his death.
>
> "There were no injuries on the … body which I would consider specific for an assault."

84. In a letter supplementing his post mortem report, the pathologist added that:

> "With regard to the absence of a ligature mark, it is not unusual for a broad soft ligature to leave very little marking in the neck … there were however internal injuries including a fractured larynx (voicebox) and bruising to the neck muscles which would not be visible to someone washing the body."

The man's clinical care

85. When the reception nurse assessed the man on his arrival at Hull on 6 May she judged him to be "very low mentally" and she referred him to the mental health team. As this was a Friday evening, this meant that he would not be seen until the following week as the mental health team does not work at weekends. She told the investigation team that she did not consider the man's mood to be so low that she needed to arrange for him to be admitted to the healthcare unit.

86. Based on the evidence available to him, the clinical reviewer does not consider that the man presented as in need of extensive mental health intervention on his first weekend in prison. He concluded that the arrangements put in place seemed reasonable.

87. While in the community, the man was in receipt of two prescribed medicines. One of these was for the control of cholesterol, the other was an anti-depressant (fluoxetine). Once again, the man had to wait until the beginning of

the following week before the matter could be dealt with and for the medicines to be re-prescribed by a prison doctor.

88. The clinical reviewer points out that fluoxetine is a long acting medication, so missing a few days of this medicine would not ordinarily result in a significant deterioration in a person's mental health. The reviewer does not believe that the fact that the man missed out on having this medication over that weekend was a major factor in the outcome. The reviewer points out, however, that those in the community do have 24 hour access to medical services. The reviewer has made a recommendation on this matter which is included in his review.

Other matters raised by the man's wife

89. The man's wife asked why her husband had been allowed a television given that it would have been possible for him to use the electric lead as a ligature.

90. The guidance contained in PSO 2700 about suicide and self-harm prevention includes advice on removal from a prisoner's possession of items that may be used to commit self-harm. Specific items of this type mentioned in the guidance include clothing, shoelaces, belts, razors, lighters, matches, plastic bags, and cutlery. The guidance explains that reducing access to the means of suicide or self-harm can form part of the care of people considered to be actively suicidal or at risk of self-harm. However, the guidance also points out that removing personal belongings from a person who feels hopeless and depressed can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Moreover, fear of losing their normal possessions can discourage prisoners from disclosing suicidal feelings and removal of some items in possession (such as pens) can deprive the individual of access to activities which might distract them from their painful feelings. The guidance goes on to make clear that where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so. Even when items are removed, staff are asked that they be removed for the briefest period of time.

91. Electric leads are not mentioned in the guidance. However, televisions would seem to be an important means of entertainment and distraction and staff would not ordinarily be expected to remove them from a prisoner's possession.

CONCLUSION

92. The man arrived into Hull on the late afternoon of 6 May 2011. Staff recognised upon his arrival that he was at potential risk of self-harm or suicide and an ACCT plan was opened for him. A key component of the plan was the support of being placed with a cell-mate. Despite initially having a cell-mate, the man was left in the cell on his own and he took his life later that evening. It is particularly unfortunate that staff did not find a new cell-mate for the man given that they had appropriately judged this to be a way of mitigating his level of risk. While the ACCT process correctly identified a means of protecting him, it was let down by the failure to record it properly and the inability to find a new cellmate.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Governor should ensure that the frequency of ACCT conversations and observations take into account all relevant risk factors.

   Recommendation accepted
   Senior Officers are taking role as case managers and following requirements of PSI 64/2011.
   All ACCTs are quality checked daily by the safer custody team.
   Any issues identified are addressed at the monthly safer custody meeting.
   Actions are in place.

2. The Governor should ensure that the setting of ACCT conversations and observations is not unduly influenced by whether the prisoner has a cell-mate.

   Recommendation accepted
   Senior Officers are taking role as case managers and following requirements of PSI 64/2011.
   All ACCTS are quality checked daily by the safer custody team.
   Any issues identified are addressed at the monthly safer custody meeting.
   Actions are in place.

3. The Governor should ensure that prisoners deemed to need support from a cell-mate are not left in a cell alone overnight, unless alternative protective measures are in place.

   Recommendation accepted
   Senior Officers are taking role as case managers and following requirements of PSI 64/2011.
   Wing Managers ensure that before final lockup, all Prisoners subject to ACCT support and the need of a cell mate are not left alone overnight.
   Any issues identified are addressed at the monthly safer custody meeting.
   Actions are in place.

4. The Governor should The Governor should conduct a disciplinary investigation into the actions of staff that led to the man being left alone in his cell without an alternative support plan.

   Recommendation accepted
   Investigation to be conducted.
   Target date is July 2012

5. The Governor should ensure that CAREMAPS are completed in line with the requirements of PSO 2700 (now PSI 64/2011).

   Recommendation accepted
   Senior Officers are taking role as case managers and following requirements of PSI 64/2011.
   All ACCTS are quality checked daily by the safer custody team.

Care maps are reviewed as an agenda item on the safer custody monthly meeting.
Actions in place

6. The Governor should ensure that staff request ambulances promptly as required in emergency situations.

   Recommendation accepted
   Protocol published and in place.
   Actions in place

7. The Governor and PCT should revise the protocol on summoning emergency ambulances to align it with the instruction contained in the local suicide and self-harm policy and the Chief Executive of NOMS's letter of February 2011.

   Recommendation accepted
   Protocol published and in place.
   In place.