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

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

The man was 24 years old when he died at HMP Risley on 24 May 2007. The cause of death was hanging.

One of my family liaison officers has contacted his partner and parents on my behalf and I would like to add my condolences to hers. I hope that their questions are answered in this report.

Two of my colleagues carried out the investigation. I would like to thank the Governor of Risley and his staff for their positive approach to my investigation, and particularly for the help of the liaison officer. I also asked for a review of the man's clinical care and am grateful to the clinical reviewer for his assistance.

The man was in prison because he had assaulted his partner. It was his second time in custody, and suicide prevention monitoring and support measures had been in place twice during his previous sentence. He was subject to a further period of monitoring and support up to a fortnight before he died.

Unlike many of those whose deaths I investigate, this man was well supported by prison staff, and all were aware that his relationship with his partner was central to his wellbeing. There is no evidence that anything else distressed him. His wish to attract her attention had led to him taking an overdose in April 2007. The relationship ended on 21 May and some thought was given to whether the suicide monitoring procedures should be re-opened. Given the circumstances, I have personally found it difficult to understand why this precaution was not taken.

Investigations of two previous deaths at Risley made recommendations concerning roll checks. It is disappointing to learn that the check before the man was found was not carried out properly. He may well have hanged himself by then, and could have been discovered an hour earlier than was actually the case.

I make four recommendations to the prison and health authorities that I hope will further develop their joint approach to suicide prevention, and am pleased that they have been largely accepted. I identify one example of good practice.

This anonymised version of the report has been prepared for publication on the PPO website.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2007**

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SUMMARY

The man was 23 years old when he transferred to HMP Risley in January 2007. It was his second prison sentence, both having been imposed for assaulting a member of his family. On this second occasion he had seriously assaulted his partner, and was serving over four years' imprisonment.

He was consistently described to my investigators as an able, motivated, intelligent and articulate young man, who liked to be in control of his life. These qualities, and his willingness to disclose his troubles, led him to seek support from a wide range of prison staff.

There were similarities between the man's behaviour during his first and second sentences, albeit for different reasons. In the first, he sought support regarding financial difficulties. He made a serious attempt to harm himself and was twice placed on suicide and self harm monitoring. In the second sentence, he was preoccupied, to the point of obsession, with his relationship with his partner. He appeared to share his feelings with everyone he came in contact with. The couple had been reconciled whilst he was on bail and continued to have daily contact for the first months of his sentence. The relationship dwindled and he began to complain about her attitude towards him.

A sentence planning meeting took place on 19 April 2007, attended by the man's home probation officer. For the first time, he told her that his partner had children. The probation officer correctly reported the information to the social services department, so that they could assess whether there were any child protection concerns.

Three days later, the man took an overdose of tablets prescribed to him for a chesty cough. The Assessment, Care in Custody and Teamwork (ACCT) procedures were opened to reduce his risk of self harm and suicide. He explained that he had taken the tablets to seek attention from his partner. Although the relationship continued to fade, one of the objectives of his ACCT plan was that he should have a supervised family visit.

The ACCT objectives were achieved, though their scope was restricted as the full range of professionals supporting the man were not party to them. The document was closed on 8 May. Those responsible were satisfied with his statement that he would give the relationship another seven days – until his birthday – and that, if it was not progressing, he would be able to move on with the rest of his life.

There were delays before the family visit took place and before social services visited the man's partner and, by a tragic coincidence, both visits took place on Monday 21 May. By all accounts the family visit went well, but during the social worker's visit later in the day, his partner said that she wanted to end the relationship. The man was distraught, and made full use of his support network. All the staff knew his situation and, although it was not a joint decision, no one thought that re-opening ACCT was necessary.

During the night of Wednesday 23/Thursday 24 May, he packed his belongings, obstructed the door panel, and apparently tied a ligature round his neck and attached it to his upturned bed. The member of staff checking at 6.00am on 24 May saw the obstruction, but took no action.

The man was discovered at the next check an hour later, by which time it was too late for resuscitation to be attempted.

THE INVESTIGATION PROCESS

1. The investigation has been conducted by one of my assistant ombudsmen, and an investigator. The investigation was opened on 25 May 2007, the day after the man died. The investigator met the Governor and some of his staff, together with representatives of the Independent Monitoring Board (IMB) and Prison Officers' Association (POA). She was briefed about events whilst the man was in custody and the circumstances of his death. She received copies of his prison records, and was given a tour of the prison, including the wing where he lived.

2. Notices of the investigation were provided for distribution around the prison, including to all the prisoners on his wing. The notices invited prisoners and staff to contact the investigators if they wished to share any information. The only response was from a man from another wing who had not known the man.

3. Interviews were conducted during the following six weeks with two prisoners from the wing, 17 prison and healthcare staff, and with his probation officer in the community. The interviews were either tape recorded or notes taken, and the record of each interview is annexed to this report. I also informed the social worker involved with the man's partner of my investigation, but have not received a reply.

4. The investigation has been considerably assisted by the helpful cooperation of Cheshire Police, who also interviewed many prisoners and staff and shared their statements with my team. The interview with the probation officer was carried out jointly by my investigators and the police.

5. I have also been assisted by the Warrington Primary Care Trust who appointed a consultant public health expert to review the man's clinical care whilst he was in prison. The clinical reviewer sought advice from a mental health specialist regarding aspects of the man's treatment. The review is also annexed to this report.

6. One of my family liaison officers contacted the man's parents and partner to ask whether they had questions for the investigators to consider. They commented on the following matters:
   - Whether he received the correct help for his problems in the community and in the prison.
   - The prison knew that the man got upset easily and had harmed himself previously. He should have been put on a 'suicide watch' again.
   - The prison would have known how he would have been affected by his partner's visit and should have provided additional support.
   - What happened during the night of 23/ 24 May?
   - Were the checks carried out correctly by staff?
   - Why was the upturned mattress not seen blocking the door?
   - What time did he die?

The man's mother also questioned the way in which the social services department dealt with the termination of his relationship with his partner. Although the work of the department is outside the terms of my investigation, I have been able to provide some information.

7. The man's father expressed his appreciation to the prison for their support following his son's death, and especially for attending the funeral.

8. I have informed the Cheshire Coroner of my investigation and a copy of the final report has been sent to assist his enquiries.

9. In the course of my investigation, information was brought to the investigators' attention regarding the conduct of the early morning roll check on 24 May. The information was immediately passed to the Governor who arranged his own investigation. Subsequently, the member of staff responsible for the check resigned from his duties. I understand that Cheshire Police have not as yet decided whether the case should be referred to the Crown Prosecution Service for consideration of further action.

HMP RISLEY

10. HMP Risley is a modern, purpose built prison which opened in 1964. It holds 1,085 men and is the largest training prison in the country. The man was held in G wing, which has 180 cells, of which 12 are double. G wing prisoners are expected to be drug free, and any who test positive for drugs are removed. There are 35 staff based on F and G wings, some of whom are also responsible for other duties in the rest of the prison.

11. Each prisoner has a personal officer who deals with any applications, such as access to offending behaviour courses and employment. The personal officer does not necessarily carry out other individual tasks such as reviewing cell sharing risk assessments or carrying out ACCT duties. There had been a policy at Risley for personal officer duties, but this had fallen into disuse and was being reviewed at the time of this investigation. Prisoners also have an offender supervisor within the prison whose role is to work with the offender manager (the probation officer in the community).

Healthcare

12. Warrington Primary Care Trust (PCT) provides a 24 hour out-patient healthcare service. Prisoners who require in-patient treatment are referred to other prisons or to outside hospital. There are 22 full time equivalent PCT staff and four from the Five Boroughs' Mental Health Trust, plus outside specialists such as dentists and opticians.

13. Prison staff are allocated radio call signs and Hotel 1 is allocated to the duty healthcare nurse who responds to any emergencies. The prison does not use code signs to distinguish between different types of emergencies, such as code red and blue, which are commonly used in other jails.

14. Suicide and self harm awareness training is not routinely provided for healthcare staff. The Head of Healthcare told my investigator that they are not routinely notified of ACCT reviews and that the PCT is not represented at Safer Custody meetings, although a mental health worker does attend.

15. The PCT employs mental health workers to provide primary mental health care to prisoners with mild to moderate symptoms. Prisoners with more severe problems are referred to registered mental nurses working for the Five Boroughs' Mental Health Trust. The man had a mental health worker who had worked at Risley on three days a week for the past three years. She has completed ACCT training. She described good information sharing within the prison and said that mental health workers are aware of all prisoners on ACCT and their review dates. She said that the arrangements for ACCT documents to accompany the prisoner had improved, so she was able to read the record and note that she had seen a particular prisoner.

Chaplaincy

16. The prison chapel is known as the All Saints Chapel and World Faith Centre. The chaplains are employed by the Prison Service and work to a national Code of Conduct which states that they are subject to the same conditions of work and code of discipline as all other staff at Risley. There are six core values and seven guiding principles. These include "the need to respect confidences and maintain security". The principles do not refer to the chaplains' responsibility to promote prisoners' safety and welfare by sharing information as necessary.

17. The chaplains receive ACCT training and are informed when every ACCT document is opened. They ensure that each ACCT prisoner is visited every day by one of the team.

Counselling Services

18. Prisoners can make use of the services of trained volunteer counsellors who come in each week for pre-booked appointments. The arrangements for their work are made by the volunteer co-ordinator. The counsellor who worked with the man was a member of the British Association of Counsellors and Psychotherapists. Her work is unpaid, but the prison pays her expenses, professional insurance fee and her supervision expenses. She has been trained in ACCT procedures.

19. The counsellor's work is governed by a contract between the prison and herself, dated 19 October 2006. Amongst other clauses, the contract sets out the prisoner's right to confidentiality and the counsellor's responsibility to override the right in specific circumstances. The counsellor is expected to share information if there is evidence that failure to disclose might breach prison security, or endanger the prisoner's life or that of another, endanger the well being of a child, seriously endanger the community or other vulnerable people, or cause a serious threat to the counsellor. She said that she makes prisoners aware of her obligation to pass on such information.

20. Although the contract expects counsellors to share information, there is no equivalent statement about the prison's responsibility to make counsellors aware of information such as a prisoner's risk of self harm or whether they are receiving support from other agencies.

21. Counselling sessions are held in rooms located on the wings and so officers would be aware that a prisoner was receiving support, whilst not knowing confidential details. Each session generally lasts for an hour. The counsellor does not keep a record of their content.

Prison Service Orders (PSOs)

22. Prison Service Orders are long term instructions from the Prison Service to Governors, each with its own title and reference number. They are

supplemented by Prison Service Instructions (PSIs), and each Governor may also issue Local Orders and Instructions.

Suicide and self harm monitoring

23. F2052SH was the suicide and self harm monitoring system in place during the man's first prison sentence. The arrangements were replaced by the Assessment, Care in Custody and Teamwork system which was introduced in PSO 2700 Assessment, Care in Custody and Teamwork (ACCT).

24. ACCT requires any member of staff who identifies concerns about a prisoner at risk of suicide or self-harm to take action and record their actions. The ACCT document should be available to all staff where the prisoner is located, including workshops and visits. Within 24 hours of an ACCT being opened, the prisoner is to be seen by an assessor and have a case review meeting. The meeting draws up a care and management plan known as a care map. A member of staff, usually the senior officer on duty at the time, is nominated to be the case manager to oversee the management of the ACCT document and attend case reviews.

25. As well as the care map, the document includes an assessment section which covers eight specific areas, each requiring a comment. The section is designed so that each area includes the action to be taken in response to the assessment, with a judgement informed by information gathered earlier. There is also an on-going record of significant events, conversations and observations which is available to all staff on duty at the time.

26. ACCT reviews are held at intervals appropriate to the actions planned in each prisoner's care map. They are attended by the prisoner and the case manager, together with other people responsible for specific actions.

27. Prisoners who are at risk of harming themselves may be offered access to a Listener. Listeners are fellow prisoners who have been trained by the Samaritans and provide confidential support.

28. In the 2007 calendar year to date (September), Risley had opened an average of 16 ACCT documents each month, applying to an average of six prisoners. In May 2007, 16 documents were opened, none of which was on G wing. On the night that this man died, five were open and a sixth was opened during the night. Five prisoners harmed themselves in May, one of whom was on G wing. There were seven occasions in the month that the Samaritans telephone was requested, none of which was on G wing.

Previous deaths at Risley

29. This is only the second death at Risley that my office has investigated since I became responsible for investigating all deaths in custody in April 2004. Although the circumstances of the first were entirely different, I made several relevant recommendations concerning the prison's response. I was pleased to

learn that my recommendations were implemented and the response to this death was exemplary.

Roll checks

30. Roll checks are carried out to confirm that the number of prisoners on each wing is correct. The standards for roll checks at Risley are set in the prison's Local Instruction Routine Roll Checks – Timing and Reconciliation 2.06, which came into effect on 1 September 2004. An additional Instruction, 2.73, expands the first. Day staff are required to carry out checks:

- before morning unlock at 7.45am
- after morning work at 9.30am
- lunchtime at 12.30pm
- after afternoon work at 2.30pm
- after tea at 5.15pm
- after lock up at 8.30pm.

Night staff are required to carry out checks:

- at the start of their duty (no time is specified)
- before the day staff start at 6.30am.

31. The instructions state that the purpose of the checks is to ensure that prisoners are in the correct cell with the door locked shut, and that the bolt is in the hole to secure the cell. Staff are also required to ensure that prisoners are safe and well at each roll check.

32. Each cell door has an observation panel with a flap that can be opened from outside. Prisoners are told at their induction that the panel must not be obscured, and staff are instructed to remove any obstructions which they find. In interviews for this investigation, it was apparent that it is custom and practice for prisoners to place temporary obstructions over the panel when they want some privacy.

33. Investigations conducted by the Prison Service itself into two deaths in custody prior to April 2004 had made recommendations concerning roll checks. The first was in February 2004 and the second a month later, and the prison's action plan included a Governor's Order to "outline the responsibility of staff carrying out roll checks … about staff's ability to both see and hear the prisoner". It added that blocked observation panels should be cleared immediately.

Night State

34. Night state describes when the prison is locked up for the night and staffing levels are at a minimum. There is often just one night patrol officer per wing, or on occasions, between two wings. Their role is to monitor the security of the wing and prisoners. In respect of G wing on the night of 24 May 2007, one

officer support grade (OSG) was responsible for the wing. He carried a radio and cell door key, which was in a sealed pouch secured to his belt.

35. The senior person on duty at night time is the night orderly officer (Oscar 1). They are responsible for visiting wings to check on the welfare of the staff and ensure they are carrying out their duties correctly. During night state it is not usual to unlock a cell unless Oscar 1 deems it necessary and has sufficient resources to deal with the situation.

36. Each duty begins with a handover from the evening staff, which is based on the evening senior officer's report in the observation book and includes the names and numbers of any prisoners requiring additional observations because they are on ACCT or are subject to Bullying Information Reports. Night staff might be asked to make additional checks on prisoners because of specific circumstances such as health problems.

Controlling Anger and Learning to Manage programme (CALM)

37. The CALM programme is one of many programmes designed to help prisoners tackle the causes of their offending. CALM aims to help prisoners deal with aggression and is run by the prison's psychology department. There is a waiting list for the programme but applications can be transferred from a previous prison sentence.

Visits

38. Prisoners are entitled to send out visiting orders to their family and friends, who telephone to book in on a specific date. Most visits take place in the visits hall under the supervision of prison officers. Occasionally, for specific reasons, family visits take place in a designated room off the hall, and may be supervised by other members of staff such as chaplains.

Independent Monitoring Board (IMB)

39. The Prisons Act (1952) requires each prison to be monitored by a Board with members from the local community who are appointed by the Secretary of State. The Board has the right of access to every prisoner and every part of the prison. Prisoners may apply to speak to an IMB member, but the man did not do so and was not known to any of the members.

40. Each IMB produces an annual report and the one for the year prior to the man's death was published in June 2007. It comments on all aspects of Risley, including the ACCT arrangements. Board members attempt to visit all prisoners who are on ACCT, although they are not always successful. They used to attend reviews held under the F2052SH process, but are not invited to ACCT reviews. The IMB's annual report says:

"At many ACCT reviews during the year only the prisoner and the wing SO are present. Without being too judgemental it is in the interest of the SO to close the file so as to reduce the resource required to support the prisoner. It is felt

that there should be a minimum of three people attending with the third attendee coming from one of the other agencies in the prison. At present healthcare do not attend if the prisoner is not on their case list."

41. The IMB is represented at all Safer Custody meetings and is involved in all discussions. Despite the Board's misgivings about ACCT reviews, their annual report confirms that they are content with the safer custody strategies employed in the prison.

Her Majesty's Chief Inspector of Prisons (HMCIP)

42. The most recent HMCIP inspection was unannounced and took place in February 2006. Aspects of the report that are relevant to this investigation include the finding that there were weaknesses in the prison's work on suicide and self harm prevention. Bi-monthly suicide and self harm committee meetings took place but were not attended by the full range of multi disciplinary staff, including healthcare, chaplaincy, work parties or education. HMCIP recommended the appointment of a full time safer custody officer. The prison has since revised its suicide and self harm strategy, and includes multi disciplinary attendance at meetings.

KEY FINDINGS

43. In September 2006, the man assaulted his partner, was arrested and bailed to appear in court in December 2006. He pleaded guilty to the offence and was remanded for sentencing in January 2007. His probation officer was asked to prepare a pre sentence report.

44. The probation officer interviewed the man twice about the offence, and was aware that he had self harmed by attempting to cut himself immediately afterwards. She described him as calm but remorseful, which was unlike his feelings about his previous offence. She thought that he was living alone and did not know that his partner had children.

45. She wrote in her report that the man recognised the seriousness of his offence, but could not explain how it happened. He had taken steps to deal with his aggressive feelings, but was waiting for the first appointment. Her report recommended that he should serve at least three years' imprisonment, to allow sufficient time to address his offending behaviour and receive support for his mental health problems. She said that he realised that a prison sentence was likely and they discussed the impact it might have, including the possibility of further self harm. The man told her that he was stable and not at risk.

46. The probation officer sent the report to the court, together with the information that the man was at risk of suicide and self harm. He pleaded guilty, and was sentenced to four years three months' imprisonment. The court duty probation officer, interviewed him afterwards and recorded that he was upset about the sentence. She saw that he had cuts on his arms, which were old wounds, and he told her that he had made them three years previously. He said he had no further thoughts of harming himself.

47. The man began his sentence at HMP Liverpool, where he went through the standard reception and induction. He named his partner as his next of kin, giving her address as his own. The officer completing the Cell Sharing Risk Assessment (CSRA) assessed him as low risk for cell sharing, meaning that there was no current evidence of risk and he was suitable for a shared cell. The officer recorded that he was not on an open F2052SH and there was no evidence of a previous document. The third part of the CSRA was completed by a nurse who confirmed the assessment, and wrote that he had no problems apart from drug abuse.

48. Four visiting orders were sent to the man's partner whilst he was at Liverpool and she visited on 22 January 2007.

49. The man transferred to Risley on 23 January, arriving at 11.55am, when he repeated the reception and induction process. The officer completing parts 1 and 2 of the CSRA assessed him as low risk, but recorded that he preferred a single cell. Prisoners are asked whether they have any concerns about sharing a cell and whether they describe themselves as someone who gets

angry or frustrated quickly. The answer to both questions on the form was negative.

50. The nurse who completed part 3 of the CSRA assessed him as medium risk for cell sharing, meaning that there was no immediate risk but the situation would need to be reviewed regularly. The form also shows that concerns were raised in the self harm assessment because of “medical issues” and his refusal to share a cell because of “anger management issues”. The nurse did not consider that it was necessary to open an ACCT document, although it was known that he had a history of mental health problems and had attempted suicide the previous year. He was referred to the mental health team because of his history of depression, panic attacks and suicide attempts during the previous year.

51. The prison’s Public Protection Unit wrote to the probation officer the day that he arrived, saying that the man was registered as a High Risk/ Dangerous offender who was to be managed as level 1 in the local Multi Agency Public Protection Arrangements (MAPPA). (MAPPA level 1 means that the offender manager and her district manager would manage any public protection issues.) The probation officer was offender manager in the community and an officer was allocated as his offender supervisor within Risley. The letter also said that victim enquiries were ongoing, but that the only issues related to self harm and mental health and there were no child protection contact issues.

52. Also on the man’s first day at Risley, he renewed his contact with one of the prison’s chaplains, who coincidentally was on duty in reception. The chaplain was surprised to see him back in prison, and the man said he thought that he had let the chaplain down by returning. He asked to come to the chaplaincy to talk about his conviction and other issues. He was emotional and felt remorseful and guilty about his offence, describing the relationship as volatile. The chaplain said the man was sensitive, bright and eloquent. He wrote in the chaplaincy contact sheet “will need to keep an eye on him”.

53. The chaplain wrote a statement to the Governor after the man’s death in which he described him as a highly intelligent young man who was polite, well mannered and meticulous in everything he undertook. The chaplain said the man was a perfectionist. He felt that they had a “good, honest and open” relationship, in which he seemed to be able to discuss personal matters. The man also had considerable contact with other members of the chaplaincy team.

54. New prisoners at Risley are located on C wing and the man remained there until the end of February. He signed the C wing compact on 29 January, agreeing that, amongst other rules, his observation panel must be kept clear at all times. He completed his induction on 2 February, identifying worries about his accommodation and a history of self harm in the resettlement record. The End of Induction report asks the officer for an assessment of the prisoner’s ability to cope, and the response was that there were no issues. The man’s CSRA was reviewed the same day and he remained at medium risk.

55. The only entry in the man's wing file whilst he was on C wing was on 30 January when his personal officer introduced himself. He applied for enhanced status and was told that he must wait for three months. No other issues were reported at the time and the form headed Initial Client Assessment (Personal Officer To Use) was left blank.

56. Soon after the man was sentenced, he wrote to his probation officer to request a copy of her completed assessment of him (known as OASys) as he thought that the one at the prison did not contain the full details of his offence. He believed that she had assessed him on the basis of his previous offence, but in fact he had not seen all the information held at the prison. Her colleagues in the victim support team were in contact with the man's partner to ascertain whether she wished any restrictions to be imposed when he was released. At the time, she did not wish any conditions to be put in place.

57. On 28 January, the man applied for a second grant from the Prisoners' Education Trust, the first having been awarded during his previous sentence when he completed the Openings course with the Open University. On this occasion, he hoped to complete his mathematics AS level. Three days later, he successfully applied for a place on the Positive Parenting/ Higher Level Learning course run by the prison's education department. The course has 20 sessions, and the records show that he participated enthusiastically and received good reports.

58. The man went to healthcare the same day, complaining of a chesty cough, sore throat and coughing up blood. He was assessed by a nurse, who gave throat pastilles and referred him to the doctor. Because the man was allergic to paracetamol, he was prescribed a 28 day supply of Brufen (Ibruprofen) tablets and advised to have plenty to drink and to keep warm.

59. Also in January, the man made another application to do the CALM course. It was not linked to his first application (made during his previous sentence), as all prisoners get a new number for each sentence and the applications were not married up. This meant that he was expected to be re-assessed rather than go straight on to the waiting list.

60. The chaplain saw the man during the first weeks of his sentence and thought that he was happy and had settled down. No reference was made to the financial problems that had beset him during his previous sentence, and the focus was now on his relationship with his partner. The chaplain knew that he received and sent daily letters to his partner, writing up to 12 or 13 pages at a time. The chaplain was not concerned about his emotional or mental wellbeing and felt that everything was going well for him. The man told him that his partner recognised that his offence was a mistake and they had resumed living together whilst he was on bail. His goal was to have a home and a job, because then he would have achieved the same as his father had done.

61. On 5 February, the man applied to use the gymnasium and was offered a class two days later. He also attended the Emergency Life Support course.

His first appointment with the mental health team was on 8 February, but he asked for it to be rearranged as he wanted to complete his gym induction.

62. A Public Protection Risk Management meeting was held on 9 February. This is a paper exercise which determines any risk management issues and the necessary actions to be taken by various parts of the prison. The form stated that there was a high risk of violence and suicide and self harm. Alcohol was identified as a particular problem. No child protection issues were identified. The man's offender supervisor was to refer him for domestic violence and enhanced thinking skills courses and also for work on his alcohol misuse.

63. On 19 February, the man went to the chaplaincy to ask the staff to find out when his partner had booked her next visit. After five or six weeks at Risley, he had started to say to the chaplain that she had stopped writing to him and was not keeping her promises to book visits. The chaplain thought the man was frustrated that his partner was not paying him as much attention as she had done initially.

64. The man used the prison's complaints procedure for the first time on 22 February, complaining that five job applications had been rejected by security. He referred to his educational qualifications and described himself as a "model prisoner" who avoided trouble, drugs and bullying. The job applications are on file, but are undated. They describe him as a "very quiet individual, keeps himself to himself and has caused no control problems". The response to the complaint from the wing senior officer was that he had not been in the prison long enough to be eligible, but he could appeal again to the Security Department. The officer also wrote that he had been informed by the chaplain that the man was "a trusted and good orderly the last time he was in Risley".

65. Although the man applied for four visiting orders for his partner in February, the only visit took place on 23 February. The chaplain commented that he telephoned the man's partner to ask why she had not arrived and then, with her permission, allowed them to speak on the phone. The chaplain described the man's behaviour as volatile between the expected visits, and said that the telephone conversations seemed to calm him. At the time the chaplain was unaware that the partner was the victim of the man's offence. The chaplain thought that the telephone calls were appropriate because they had been living together and because his partner agreed to accept each call.

66. The man was offered an alternative mental health appointment on 27 February, when he met his Mental Health Support Worker (MHSW), for the first time. The MHSW routinely asks prisoners about their risk of self harm, and the man denied that he had any current thought of harming himself. He blamed his earlier attempts on the breakdown of previous relationships. The MHSW felt that the relationship with his partner was "a protective factor", preventing him from harming himself. The MHSW described the man's appearance as well kept and said that he made good eye contact throughout their meeting. He told her that he had good support from his partner.

67. The man told the MHSW that his sleeping pattern was changeable, depending on his worries, and he was isolated and alone. He said that he experienced the problems every day, and they were worse when there was little activity and he was locked up. He thought that difficult experiences in his early childhood were relevant, and said that every day he and his mother experienced his father's violence. His assessment of his difficulties on a scale of one to ten was that they were scale three.

68. The MHSW learnt that the man was not working in the prison and wanted to have a challenging, rather than a monotonous, job. He said that he had good support from the chaplaincy, even though he did not have a religious faith. The MHSW assessed that he was very willing to engage with her, was motivated and able to concentrate, and had some insight into coping strategies. They agreed to continue one to one meetings when they would identify the goals for his contact with mental health services. In the long term, he would undertake self help work on his behaviour. They aimed to reduce his anxiety levels and improve his mood. He completed a goal planning sheet that identified three goals and the steps necessary to achieve them, together with any potential obstacles.

69. The man moved to G wing on 28 February, and was allocated cell 2-44 which is a single cell. He signed the G wing compact indicating that he intended to abide by the wing's rules. Two days later he also signed the voluntary drug testing compact. He was tested eight times and produced a negative result on each occasion.

70. On 2 March, the man appealed about the outcome of his complaint about job applications and was told that there was a three month waiting list for the jobs.

71. The second appointment with the MHSW was on 6 March. She recorded that he wanted to increase his understanding of his feelings and the reasons for low periods. He denied any thoughts of self harm and repeated that he had good support from his partner, even though there were difficulties concerning their trust and control of each other. The man told the MHSW that he found it difficult to understand that his partner might go out whilst he was in prison. The MHSW encouraged him to challenge any negative thoughts with more positive and rational ones, writing them down before the weekend so that he could use them when he felt particularly low.

72. One of the tools of the MHSW's work is a book called "Overcoming Depression" which she lent to the man. She said that he read the chapters which he thought were relevant. She recorded that he displayed many unhelpful thinking styles and she gave him information about dealing with them. No other problems were reported and he said he had settled in well on G wing. The MHSW thought that he might be better in the new wing because it is smaller and the prisoners tend to be more mature.

73. The man saw the prison doctor on 11 March regarding a skin rash on his body. The same day he made a third complaint, saying that when he arrived at Risley he had referred himself for counselling. He wrote that he had applied

again every week but had not heard anything. He had “a number of issues which he needed to resolve, concerning family and relationship problems and anger”, and felt that he needed the sessions for his own well being. The response was that there was no record of his applications, and he was seen straightaway to make a new referral. The volunteer coordinator told the man that he would be offered an appointment as quickly as possible, subject to current waiting lists. She recorded that he seemed happy that his complaint was being dealt with and thanked her for her intervention.

74. One of the man’s friends on the wing told my investigators that he knew him as well as anyone there. He described the man as a private person, and said that some prisoners did not interact with him. He would greet people, but was not especially close. His friend said that he did not think the man had any problems with prison life and was not bullied by other prisoners. At first the man did not have a job, but his friend thought he gradually relaxed into prison life, got a job and began going to the gym. The man’s friend knew about his problems with his partner when she did not respond to letters and telephone calls. He suggested that he was trying to control her from within the prison, which the man conceded. His friend talked to him about life for families outside.

75. On 17 March, the man used the complaints procedure again, this time in respect of his application for the CALM programme. He explained that he had been assessed during his previous sentence and was waiting for a place. He wrote that, although he was currently seeking help from the mental health team and had applied for counselling, “I feel I need urgent input from the Psychology Department for my own well being. I have a history of anger, depression and mental health problems and I am eager to address these problems as soon as possible.” The response was that the treatment manager was not in at the time and the complaint would be drawn to her attention.

76. The following day the man made another complaint, writing that his reception parcel had not arrived and he had been told that it was not at the prison. He was advised to ask his partner to ask the Post Office to investigate. He complained again the next day, writing that he had not had the opportunity to contribute to his OASys assessment. He said that it contained incorrect information and he wanted to be involved in the assessment process. The response was that the OASys was the responsibility of his probation officer who would be reviewing it in the near future.

77. The medical record notes that the man did not attend his next appointment with the MHSW on 19 March, and an alternative was arranged for eight days later. In the meantime, on 26 March, he was given another 28 day supply of Brufen tablets.

78. The man went to his third appointment with the MHSW on 27 March. He told her that his mood was low and that it was worse in the evening when he was alone. The MHSW recorded that he was finding it difficult to adjust to prison life and was putting pressure on himself and his partner. He was able to rationalise his negative thoughts whilst in the clinic, but said that he found it

more difficult when he was alone. He told the MHSW that he attended parentcraft classes each morning, but was alone in the afternoon. He hoped to get work in the kitchen, gardens or chaplaincy, and dismissed her suggestion of the workshops.

79. The MHSW considered that the man was isolating himself on the wing and they talked about how mixing with other people would benefit his mood. She set goals to encourage him to be more sociable and advised him to ring his cell bell if he felt low at the weekend. She also suggested that he refrain from writing to his partner every day so that they would have more things to discuss. Although his mood had deteriorated, the MHSW was not sufficiently concerned that she felt she should report it to the wing. She arranged to review him in two weeks or sooner if required.

80. The volunteer coordinator returned to see the man on 29 March and told him that his first counselling appointment was offered for 5 April. She noted that he appeared anxious to write the date down.

81. The chaplain continued to see the man every couple of days in the chapel services and discussion groups, as well as when wing staff reported that he was depressed and was asking for a one to one meeting. The chaplain tried to encourage him to recognise that the relationship with his partner could not succeed without the determination of both parties, and that it might be time to put it behind him. The chaplain told my investigator that he began to be concerned about the man's frame of mind.

82. The man was seen in healthcare by a different nurse on 2 April, complaining of depression and difficulty sleeping. He refused medication for depression and was prescribed a sedative to relieve his insomnia.

83. The counsellor had her first session with the man on 5 April. She described him as an open, intelligent and articulate young man, and they discussed his family background and his general situation. He told her about his anger problems and they spoke about his offences. In her statement to the police, the counsellor said that she thought the man had assaulted his partner because of his need to control the relationship. The counsellor thought that remorse was the catalyst for his motivation to change his behaviour. Either at this or a subsequent meeting, he told her that he had previously harmed himself, but she did not think it was a current issue. The next counselling session took place on 11 April.

84. The final parentcraft session was on 12 April. Each piece of work received the teacher's approval and the only record of a disagreement with one of the man's entries was at the penultimate session which covered children's behaviour. He wrote that, "if they still carry on with the behaviour a punishment is enforced. Either time by themselves, loss of privileges or at last resort a light slap." The teacher underlined the final three words and commented that "you shouldn't need to slap".

85. Although the man began the joinery course on 16 April, his attendance in the first week was haphazard as he had appointments with healthcare, probation and counselling. During the week some of the other prisoners asked the instructor where “psycho” was. The instructor’s statement to the Governor notes that it was common knowledge amongst prisoners that the man was having problems with his partner.

86. One of the man’s friends in the class was at the time was on a different wing. They got to know each other through work, and the friend described the man as a nice guy. He said that he kept himself to himself, but thought that this was because he did not follow a football team, and said that other prisoners treated him well enough.

87. The third counselling session took place on 18 April.

88. A sentence planning meeting was held on 19 April, attended by the man, the offender manager and offender supervisor. The full OASys document was available and the man’s misunderstanding was clarified. The offender manager had not seen him since before he was sentenced. She thought that he appeared stable, happy and content about his relationship. Four objectives for the next review period were agreed. He was to take part in the CALM programme, seek housing advice, develop vocational skills, and maintain his emotional stability through contact with the mental health team. The offender manager said that he was always willing to work on his objectives and carry out offending behaviour programmes.

89. In the course of the meeting, the man made the offender manager aware for the first time that his partner had two children. He said that they had been to visit him in prison and she told him that she would have to consider whether there were any child protection issues. He provided details of the children’s names and dates of birth for her records. The offender manager subsequently checked with her colleagues in the victim support team, who had also been unaware that children were involved, and then with her manager. They recognised that there might be child protection concerns and so she telephoned the local social services department, confirming the information by letter on 27 April.

90. The man went to the chaplaincy at 2.00pm on 21 April to see whether his partner had booked a visit for the following Monday. She was telephoned and said that she had not managed to get through to the visits booking number. The chaplain telephoned her again later, but got no reply. Later that afternoon, the chaplain spoke to one of the wing senior officers (SO) about the situation and recorded in the man’s chaplaincy contact record that the partner was the victim of his offence. Another attempt was made to telephone her. This too was unsuccessful.

First self harm – 22 April

91. The man did not go to the Sunday service in the chapel as he usually did. At 3.45pm, the chaplain was telephoned by a G wing officer and asked to see

him as his mood was “very low”. The chaplain said that he would be there in half an hour after he packed up the equipment from the service.

92. At about the same time, the man told a wing officer that he had swallowed 94 Ibuprufen tablets. He was taken to healthcare to be examined and an ACCT document was opened. The ACCT plan noted that the man should initially be observed twice every hour, and should acknowledge the member of staff at least twice. His medical record shows that the tablets were Brufen and that he had taken them because of an argument with his partner. He told the nurse that he had been experiencing paranoid ideas.

93. The chaplain reached the wing at about 4.10pm to be told that, in the interim, the man had gone to healthcare as he had taken an overdose of tablets. The chaplain was surprised by the information as he thought that the man was strong, had a high intelligence, and was determined to get through any difficulties. He went to see him straightaway and was told that the tablets were either saved or from other prisoners, and that he had taken them because he felt let down by his partner. The man wanted the chaplain to tell his partner what he had done, and to explain that he had taken the overdose because of her.

94. The man was transferred to Warrington General Hospital’s Accident and Emergency Department for treatment. At his insistence, the chaplain went to the hospital to see him at about 6.30pm. It was an unusual request, but the chaplain felt it right to agree as the man was panicking about having taken the tablets. His manner had changed by the time the chaplain arrived. The chaplain wrote in his police statement that he was not convinced that the tablets had actually been taken, as he thought that the man’s manner was jovial. The chaplain asked him whether he actually had taken the tablets, and he replied that the evidence was that his mouth was coated pink. The man asked him again to contact his partner, but the chaplain felt it was inappropriate. The nurse told the chaplain that she thought the man was fine, and so the chaplain decided to leave the hospital.

95. The man returned to the prison at 11.00pm when the nurse he saw on 28 January was on duty and saw him in healthcare. She was aware that an ACCT document had been opened. She checked the man and asked about the overdose. He assured her that he had no more thoughts of harming himself. She described his mood as miserable and low, and she thought that he regretted his actions. He was escorted to G wing, vomiting on the way back, which the nurse felt would be good for him.

96. The ACCT observations were carried out as required, but there was a delay completing the immediate action plan. It should have been prepared when the document was opened, but was overlooked until 9.30am the following morning (23 April). The SO was the man’s ACCT case manager and prepared the plan. Five immediate actions were identified including remaining in a single cell, hourly observations with at least two conversations, access to the Samaritans telephone and Listeners, and healthcare informed about

medication in his cell. The SO also arranged for an ACCT assessor to interview the man prior to the first ACCT case review that afternoon.

97. The SO described the man as calm but embarrassed about his actions, and she believed that he was being truthful when he said that he had no intention of harming himself again. She said that he was completely open about why he had overdosed and she felt he had no reason to lie about his future intentions.

98. The man saw the prison doctor during the day as a result of the overdose and ACCT document. The doctor's statement to the police refers to their discussion of the man's relationship with his partner. The man told the doctor that they had been arguing and she was never at home to receive his calls. He and the doctor spoke about his jealousy, insecurity and difficulty managing his temper, and their origins in the violence during his childhood. The doctor described the man as open and articulate during the conversation, and making good eye contact. He did not appear depressed and presented in a stable and appropriate manner. The doctor concluded that the overdose had been an impulsive act that the man now regretted and had no intention of repeating.

99. The doctor reassured the man and advised him to make fewer telephone calls to his partner. He arranged to follow up in two weeks, rather than the customary one week, as he was not concerned and knew that he was also being supported by a mental health nurse and counsellor.

100. The man did not go to the joinery class and the workshop instructor noted that the wing had told him he was having problems. The instructor described the man as a quiet and intelligent young man who had been a peer tutor during his previous sentence and helped other prisoners with their courses. He was a quick learner, who tried to complete tasks as quickly as possible to a good standard.

101. Later in the day (23 April), the man went to the first ACCT review. This was chaired by the SO and also attended by an ACCT assessor. The SO explained that she decided who should attend the review, based on information from the man who told her that he was in contact with the chaplaincy. She did not have any other guidance about who should be invited. The chaplain said that he was not aware that the review was taking place and was not asked to attend.

102. Summarising the review, the SO wrote that it was obvious that the man had had time to think about his actions and now felt embarrassed about what he had tried to do. The trigger for his self harm was recorded as a change within the relationship with his partner. Many of his anxieties were said to focus on the relationship, and the chaplaincy was trying to arrange a family visit. The SO believed that the visit would help him, and he said that he no longer wanted to harm himself and agreed that it would be better if he talked things through with staff. A care map was prepared that identified two issues (relationship anxiety and childhood problems) and two actions (family visit and appointment with psychiatrist) to be carried out by the chaplaincy and

healthcare. The SO said the man's demeanour was consistent throughout the day.

103. The ACCT observations were reduced to three observations and conversations during the day and three at night. The man was to be reviewed again on 1 and 8 May. The observations were carried out as required and entries made in the ACCT records by a range of wing and other staff. The quality was regularly checked by wing managers.

104. Also on 23 April, the chaplain spoke to the man who said that he wanted to telephone his partner to find out why she had not come to visit him. The chaplain wrote in the chaplaincy log that the man had admitted he had not actually taken as many tablets as he had first said. He noted that they had a good chat and he had told the man that he should not be deceitful as it could lead to problems. The chaplain said that the man began to be very open with him and they agreed that he should work out a strategy for his life inside and after prison, with or without his partner. He said the man disclosed information about his background that he felt needed more specialist help. The man agreed that he needed psychiatric help and they decided that a request would be passed to healthcare.

105. The volunteer co-ordinator heard about the man's overdose and passed the information on to the counsellor when she arrived at the prison on 24 April.

106. The workshop instructor knew of the overdose from the internal prison intranet. He learnt of the ACCT document from the man, who asked to speak to him after he arrived at the workshop. (The SO acknowledged that there should have been an ACCT action point to notify the workshop that one had been opened, but it was overlooked.) This was the first time the instructor had known of an ACCT prisoner being on his course. The ACCT form was not delivered to the workshop and so the instructor was unable to learn the man's history or record any observations.

107. The instructor spoke to the man in a separate room and the instructor thought that he was distressed. The man wanted to continue working to take his mind off his worries. The instructor knew that the man had talked to other prisoners about his problems with his partner. He thought that the man was agitated and described him having a fixed glare, and did not think he was concentrating on what he was doing. The instructor observed that the man did not appear to be concentrating sufficiently to work with joinery tools and so asked for him to be returned to the wing. He said that the man agreed with the decision, saying that it gave him the chance to sort out his problems. The instructor contacted the wing to ask for more information, particularly concerning the man's suitability to work with tools. He said he was advised that he should decide as he was in charge of the workshop.

108. The chaplain went to healthcare to refer the man for psychiatric assessment, and was told to put it in writing. He prepared a memo, setting out the reasons for his referral and took it back. He also contacted the man's partner during

the day. She told him that she would be meeting social services to discuss her children.

109. The chaplain recorded that he attended an ACCT review on 24 April, which was his first involvement with the procedures in place for the man. He thought that he was very depressed about his relationship and so the ACCT document should remain open.

110. In the afternoon, the man went to the chaplaincy as he said he had some bad news about access to his partner and her children. He spent about 45 minutes with the chaplain. He was upset and they talked about dealing with his problems. The man said he was not going to do anything to harm himself again. When he calmed down and said he felt fine, the chaplain took him back to G wing. The chaplain recorded in the chaplaincy log that the wing was "alerted to keep an eye open for him". He also noted that he was concerned about his psychological state as there were possible mental health issues. The chaplain wrote a referral to healthcare for a psychiatric assessment which he delivered and discussed with one of the psychiatric nurses.

111. The man went to the chaplaincy again the next day (25 April), and talked to a different member of the team, the co-ordinating chaplain. He noted that the man was seen in the chapel as he was on ACCT and was okay.

112. The man's fourth counselling session was booked for that day. He bumped into the counsellor beforehand and asked if the session could take place at the chaplaincy instead of the wing, and this was arranged. The counsellor knew that the ACCT document was open, but it did not accompany the man to the session and she did not make any entries in it. He talked about the overdose and the ACCT document, saying that he had had a row with his partner and had taken the tablets as a cry for help

113. The counsellor thought that the man enjoyed their sessions. He was always ready and prepared when she arrived. She said the sessions were increasingly dominated by discussion of his partner which he described as his obsession. She tried to encourage him to think about other things in life, but made little progress. The counsellor said the man did not seem to know where he stood in relation to his partner. This did not fit with what he wanted, and he found it difficult to cope with.

114. On 26 April, the man did not go to the joinery class in the morning but saw the co-ordinating chaplain at the chaplaincy. The chaplaincy log confusingly notes that his partner had booked a visit, but that she had not yet made the booking.

115. The man's friend from the workshop moved to the same wing at the end of April and they got to know each other better. At the time the man was on ACCT and was away from work. His friend was trying to give up smoking and offered him his tobacco. He said that the man was very grateful, as he had not been getting any money from outside and had been borrowing tobacco. His friend told the police that the man spoke to him about his relationship difficulties, and that he had been placed on ACCT and removed from the

joinery class. The two men spent time together and his friend reassured the man about his worries, all of which centred on threats to his relationship with his partner. He said that other prisoners in the class used to tell the man that his partner was not good enough for him.

116. The SO saw the man on the wing each time she was on duty, as well as at ACCT reviews. She said that some days he was fine, but this depended on his conversations with his partner.

117. The ACCT record includes an entry about the discussion between the instructor and a wing officer who explained that the man could not be excluded from the workshop simply because of ACCT, and that his mood should be monitored each day. The man went to work in the afternoon when the instructor observed that he was quiet, did not mix with the rest of the group, but carried on with his work without any problems.

118. The man told the instructor the following day that he was concerned about his partner and the instructor attempted to contact the chaplaincy on his behalf. The man was upset as his partner had cancelled a visit, and asked to finish work early that afternoon. The references to the possibility of a family visit continue, interspersed with comments that he was quiet. His mood varied from upset to happy, depending on whether the visit was to take place or not.

119. The man went to work on 27 April and again the instructor was concerned about issuing tools to him. The man asked to speak to him, and said he was distressed. The instructor again decided that he should not be at work. He said that all the man talked about was his partner. (The ACCT document had not accompanied the man to the workshop, and he was unable to record his observations in it.)

120. The same day, the man went back to the chaplaincy and talked to the co-ordinating chaplain again. A telephone call was made to the man's partner, and it was noted in the chaplaincy log that she said she had been unable to arrange a visit.

121. On 28 April, the SO talked to the man and noted in the observation book that he kept enquiring about the family visit, becoming upset because his partner had not yet made the booking. The SO said that he mixed with other prisoners and was not isolated, although he was not part of a specific group. As well as talking to the man, the SO also observed his behaviour. He was not at all nervous or secretive, which she took to mean he was not at risk of harming himself.

122. The chaplain next saw the man on Sunday 29 April at chapel. He noticed a change over the previous six days. He was no longer depressed but in an "an upbeat mood".

123. The fourth appointment with the MHSW was on 30 April. She was informed of the overdose when she arrived at the prison and read the healthcare observation book to find out what had happened. She knew that the ACCT

document was open and asked why he had taken the tablets. He described the overdose as attention seeking rather than an act of self harm or an attempt at suicide. He said that he wanted his partner to notice him. The MHSW did not reassess the risk of suicide or self harm.

124. The MHSW recorded that the man was very insecure about the relationship as he liked to be in control. His behaviour was described as impulsive when it was not possible for him to take control. He denied any current thoughts of self harm and was looking forward to his partner's visit on Wednesday as there were many issues that he wanted to discuss. The man told the MHSW that he was also supported by the chaplaincy and his counsellor, and she thought that they would also realise that his relationship with his partner was a protection against self harm.

125. The man spoke to the MHSW about the goals set by his offender supervisor and probation officer. He told her that he had recently begun the joinery course and seemed to be enjoying it. The MHSW agreed to contact the CALM tutor to enquire whether he needed to be reassessed and how long he would have to wait for the programme to begin. She planned to review him again in a week's time. She explained to my investigator that the frequency of appointments depended on her own availability as much as the prisoner's needs.

126. The workshop instructor discussed the man with the SO on 30 April as he was concerned about his frame of mind whilst working with dangerous tools. In interview, the instructor explained that he thought that the man was distracted and was not concentrating and might accidentally harm himself. He was not worried about him deliberately harming himself with one of the tools.

127. Another ACCT review was held on 1 May at 10.00am attended by the man, the SO and the chaplain. The SO wrote that the man was still very anxious and unsure about the relationship with his partner. He thought that his partner was trying to distance herself from him, whilst talking as if everything remained the same. The SO confirmed that the relationship was the sole source of his distress and no other worries were ever reported. The man was said to be confused and frustrated by waiting for her letters. He asked for a family visit to sort things out. The chaplain was going to arrange the visit, which he thought would help stabilise the man. The chaplain was also going to contact healthcare to arrange a meeting with a psychiatrist.

128. The frequency of the night time observations was increased to two hourly, and three observations continued during the day. The ACCT record makes frequent reference to the man's feelings about his partner. The SO told my investigator that he did not say he had any thought of harming himself, and she did not think that he was sufficiently upset to do so.

129. In the chaplain's statement to the Governor, he referred to the ACCT review and wrote that the man said he had taken the overdose because of difficulties in his relationship with his partner. The chaplain thought that the man was open and honest with him. The man told him that he thought his partner

behaved inappropriately, giving examples such as promising to book visits and then making excuses.

130. The chaplain wrote in the chaplaincy log that he telephoned the man's partner after the review and the visit was arranged for 7 May at 9.15am. He explained the procedures to her. The chaplain described the man as pleased, rather than elated, by the prospect of the visit. He spoke about giving his partner until his birthday (15 May) to decide whether their relationship should continue. He said he would then stop trying to sort out the relationship and would move on with the rest of his life.

131. The first of the man's friends said that the man did not behave any differently whilst the ACCT document was open and he was not worried about him. He knew that he talked to staff, which he said was uncommon for prisoners.

132. At 9.00am on 2 May, the man was sent back to the wing from work. The ACCT record notes that he said that the instructor did not want him to work with tools. This was subsequently confirmed, and it was noted that the instructor felt that he was a danger to himself as he was not concentrating on using the joinery tools.

133. Later that morning, a third member of the chaplaincy team, noted that the man was feeling better and had written to his partner. The third chaplain described the man as "very controlling and reluctant to allow [her] to decide for herself what she wants to do".

134. The prison's volunteer counsellors met that day and discussed when to report suicide and self harm concerns. Afterwards, the co-ordinator and the counsellor discussed the man's situation. In interview for this investigation, the counsellor said she thought that the man was happy with his experience of counselling, but that he was "very focussed on his girlfriend and everything appeared to be centred on her". The man had his fifth counselling session that day. The counsellor described him as a little brighter, and he told her about the time he spent at the chaplaincy and the support he received there. She said that he had told her that "it was a silly thing to do" to take an overdose, and that he was unable to attend his joinery class whilst he was on ACCT.

135. The ACCT record states that the workshop instructor went to the wing on 3 May, but his own statement says that the conversation took place two days earlier on 1 May. The instructor says he explained to the man that, because of the risk from the tools, he should not return to work until he felt better. The SO recorded that all parties agreed that he should have a week off work on full pay. The SO said that the intention was for the man to miss work in order to sort himself out.

136. Also on 3 May, the man was visited by the first member of the chaplaincy team who noted in the log that he was "relatively ok, though still hoping to keep his girlfriend, while learning to be realistic".

137. The man's friend who he met at the workshop told the police that he and the man spoke together frequently and visited each other's cells. He remembered an occasion at the beginning of May when the man showed him the letters and pictures of his partner and her children. He told his friend that his partner was all that he had in the world.

138. The workshop instructor spoke to the SO about the man on Friday 4 May. The SO told him that the man appeared much better, and that his partner was coming to see him to sort out their problems.

139. On 5 May, a fourth member of the chaplaincy team saw the man and found him calm but a little tense. He told her that he was fine but would be telephoning his partner shortly and did not know what the outcome would be. She recorded that they talked about the need to be philosophical about events outside prison as he could not influence them, and wrote that the man needed "a more positive coping strategy than just getting frustrated and anxious".

140. The man went to chapel on Sunday 6 May and told the chaplain that his partner had cancelled the visit planned for the following day. The chaplain described him as disappointed, frustrated and angry, as he had been looking forward to seeing her. He calmed down and the chaplain made several attempts to contact his partner about the visit. The chaplain eventually spoke to her, allowing the man to speak briefly. He said that they spoke amicably.

141. The man returned to work on 7 May, telling the instructor that he was okay. He was allowed to remain. From then on, the instructor noted that the man seemed fine and carried out his work to a good standard. He saw a big improvement in his mood. The man told him that his partner was coming to see him. The instructor observed that the chaplaincy had passed on the information that the man's partner had been booking and cancelling visits, and this seemed to affect his moods.

142. The chaplain checked with the visits clerk, but a visit had not been booked. He saw the man later in the day and found him to be more positive. He said that he would be coming to the chaplaincy in the afternoon. Later that evening, a wing officer noted that the man was in good spirits and could not wait to come off ACCT.

143. The man's CSRA was reviewed on 8 May by a wing officer who knew him from working on the wing where she had carried out some of the ACCT observations. She described him as a quiet person who only approached staff with specific requests such as to go to the chaplaincy. She had formed the impression that the man did not like dealing with female officers. She noticed that he had been sad whilst he was on ACCT because of his relationship, and said that the chaplain told her about the difficulties. The officer thought that all the wing staff shared the knowledge about the importance of the relationship. She had noticed that the man had recently seemed happier and had been interacting more with other prisoners.

144. The officer explained that the CSRA review is a paper exercise which is not carried out in conjunction with the prisoner or their personal officer. She said that the assessment remains the same as previously unless further information is supplied to alter the judgement. She had no additional information about the man and so recorded that he remained medium risk and should be reviewed every three months. Under the action required, the officer noted that the man had “medical issues”, and easily became frustrated due to anger management problems if sharing a cell. The review was not counter signed in the appropriate section by the duty governor.

145. Another officer also knew the man from working on G wing. He said that he was a quiet prisoner who would always be ready before he had to be locked up and never drew attention to himself. He knew that the man was on ACCT, and was aware of the difficulties in his relationship with his partner, but had not provided any personal support.

146. The prison doctor’s follow up appointment took place on 8 May when the man was still on ACCT. The doctor concluded that he would not plan further follow up. His police statement indicates that the doctor felt the man was positive and upbeat about his partner’s imminent visit. Although the man thought that their relationship was improving, the doctor discussed alternative scenarios and judged that he gave satisfactory replies.

147. The chaplain was invited to attend the ACCT review and went to the wing at 9.55am where the man met him and said that he wanted to come off ACCT. The chaplain said that they would consider the facts at the review which was to be attended by the man, the SO and the chaplain. The chaplain and the SO spoke together first, and then the man was invited to join them. The report of the review is timed at 4.00pm, although the chaplain said that it took place at 10.00am. It notes that the man was more “up beat” and his speech was extremely positive. He was described as realising that he needed to move on with his life even if this was without his current partner.

148. The chaplain felt the man was beginning to come to terms with his problems, and wanted to get on with his sentence and return to work. The SO described their efforts to gauge the man’s reaction to the possibility of the relationship ending. She was confident that he was being open when he said that he would have to move on with his life. She, the chaplain and the man agreed that the document should be closed and the ACCT monitoring should cease. A post closure review was planned.

149. The psychology department responded to a further complaint about the place on the CALM course, telling the man that his application might have been misfiled with that of another prisoner by the same name but would be dealt with. As the programme was not due to start until July, the man was told that he was not being disadvantaged in the meantime.

150. The man’s wing file for the same day records that he received a certificate from the Social Life Skills department. The certificate is actually dated 18 May

and was awarded for participation in the Parentcraft and Reading Together course.

151. On 9 May, the man was assessed in the mental health clinic by a Registered Mental Nurse (RMN), following the referral from the chaplain. She was aware of the man's previous meetings with the MHSW and recorded that he had various problems stemming from his childhood. He said he had no current thoughts of harming himself and was to be given anger management booklets and begin a "Thought Diary". The RMN decided that regular meetings were required and she would review him in two weeks.

152. The man had his sixth counselling session on 9 May. The counsellor thought that his mood was brighter.

153. In between the ACCT document being closed and the post closure review, the SO continued to see the man on the wing when she was on duty. She described him as very happy as he thought that the relationship with his partner had resumed and everything was okay. She confirmed that other wing staff were also aware of his change of fortune and happy frame of mind.

154. The ACCT post closure review was recorded as taking place on 8 May at 9.00am with the man and the SO. However, in her statement to the police, the SO confirmed that it was actually held on 14 May. She called the man to the wing office and they spoke together. Because she had seen him frequently in the meantime, the SO knew his frame of mind and the post closure review was a formality. She and the chaplain had also discussed the man's progress several times.

155. The SO recorded that the man remained "up beat and positive during the review". He told her that he felt better after a visit from his partner as he had been able to sort out his misunderstandings with her. He was described as aware that he must not allow his relationship to take him so low that he felt like harming himself. The man would remain in contact with the chaplaincy for support, and said that he would tell staff if he felt low again.

156. Tuesday 15 May was the man's 24th birthday. The chaplaincy log for the day notes that his partner did not come for the visit as she did not have the bus fare, and had re-booked for a later date. The chaplain described the man as a little angry and told him that he should go to work as normal, in spite of his disappointment, as he needed to keep himself occupied. The chaplain agreed to make a final attempt to arrange the family visit, which was booked for 21 May.

157. The probation officer and her district manager held a high risk review of the man's case on 15 May. She was asked to repeat the OASys assessment to coordinate with the new sentence plan. She was also asked to liaise with the social worker again (as she had not received a response to her previous communication) and ensure that the man's partner had appropriate support as the victim of his offence.

158. The following day, the volunteer co-ordinator and the man's counsellor met again. The counsellor was asked to pass a questionnaire on communication to the man at the counselling session (his seventh) later in the day. The man told his counsellor that he would complete the survey and return the form at his next session on 23 May. The counsellor said that the man was very happy as he had received a birthday card from his partner's mother. He also told the counsellor that his partner had visited him in the morning before the counselling session.

159. The man's friend thought that he seemed to improve in the week because he was getting letters, visits and telephone calls from his partner. He knew that the man was looking forward to a chaplaincy visit on 21 May. The SO said that she continued to see the man frequently when she was on duty. She said that he was not shy about speaking to staff and she was able to see that he continued to be fine.

160. The man went to chapel on 20 May and the chaplain explained the arrangements for the visit booked for the following day.

Monday 21 May

161. The man did not go to the joinery class in the morning because the family visit was booked to take place between 9.15am and 11.00am. The chaplain, the man and his partner were present throughout. Afterwards, the chaplain wrote that he thought the visit went extremely well and that "the two partners seemed very well reconciled". He noted that the man told his partner he would not try to control her. The man told the chaplain that, on a scale of one to ten, he was on nine, and thanked him for organising the visit. The man's friend also noticed that he was happy after the visit, which he said had gone well.

162. The same day, the man used the complaints procedure once more. He complained to the prison's psychology department about his failure to get a place on the CALM programme. He recounted his previous complaint, clarified his previous prison number, and asked when a place would be offered. In his complaint form, the man said that unlike most prisoners he was keen and highly motivated. The reply confirmed that his original application had been linked to the second. He just had to wait for the course to start and did not need to be reassessed.

163. Also on 21 May, a child protection social worker visited the man's partner regarding the information from his probation officer. Although the social worker has not provided any information for this investigation, a copy of her police statement has been supplied. Initially, the man's partner said that, although the relationship had come to an end, she thought they might be reconciled and so took her children to visit him. However, she went on to say that she only visited because she was frightened of what the man would do to himself and to her. She was adamant that she wanted to end the relationship as she was frightened of him. She knew from the chaplain that he had taken an overdose and said he had written threatening to harm himself again.

164. The social worker advised the man's partner of possible future action by her department if the relationship continued and it was necessary to safeguard the children. She also made his partner aware that she would continue to liaise with the probation officer.

165. An Officer Support Grade (OSG) was on night duty on G wing for the week beginning Monday 21 May. He had been doing the job for 14 years and regularly worked at night on G wing. The OSG had been trained in fire safety, first aid and ACCT procedures. In interview, the OSG said that his duties did not bring him into physical contact with prisoners. But he did get to know them from carrying out roll checks and doing ACCT and other observations.

166. The OSG's night time routine includes roll checks of all prisoners at the start of the night and at 6.30am before going off duty. The OSG said he would look through the observation panel into each cell to see the prisoner, but would not wake them up. He said that, if an observation panel is obstructed, he is told to get a response from the prisoner. When the checks are complete and the roll known, the OSG records the figures and signs to confirm that the task was complete. Throughout the night, the OSG said he would patrol the wing every hour, using a pegging gun to confirm his route which goes past every cell.

167. The OSG confirmed that he knew the man from when his ACCT document was open. He described him as a quiet prisoner who did not present any problems and never rang his bell to ask for anything. They only had brief conversations, even when the ACCT document was open.

Tuesday 22 May

168. The social worker spoke to the probation officer after her visit to the man's partner, and reported that she said he was controlling which made her unhappy. She passed the information to the probation officer that the man had attempted to take an overdose, and threatened to do so again. The social worker then telephoned the man's partner, and was told that she had already sent a letter to end the relationship. The social worker contacted the probation officer again to tell her about the letter and ask for any information about further contact between the man and his partner.

169. The probation officer had been unaware of the self harm and so telephoned the prison healthcare team for verification. She told the Deputy Head of Healthcare that the man's partner was likely to end the relationship and she was concerned about his risk of self harm and suicide. The probation officer said that the call was returned and her identity was confirmed, together with details of the overdose the previous month.

170. The probation officer then telephoned the prison's security department, and was told that the staff were in a meeting. She also telephoned the man's offender supervisor. However, his telephone was on voicemail and she left a message that she had rung. She did not explain the reason for her call as she had already reported her concerns to healthcare. Finally, the probation officer

contacted the victim support team to ask for the man's partner's needs to be reassessed as her situation had changed.

171. The chaplain received a telephone call from the man's partner at about 1.30pm in which she said that she had had some bad news from social services. She had been visited by a social worker the previous day and told to break all contact with him. The conversation with the chaplain lasted about 15 minutes, and he described her as weeping and distraught about the news which she asked him to pass to the man. The social worker had told her that she had been told by probation that his mail and telephone calls would be monitored. The man's partner said that she was warned that, should she not end the relationship, her children would be entered on the child protection register and risked being taken into care. The chaplain wrote in his statement that the man's partner was upset during the conversation. She said that the social worker considered that he was a danger to the children.

172. The chaplain discussed the information with the co-ordinating chaplain and they decided to pass it to the man in person. The chaplain sent a message to the wing to ask the man to go to the chaplaincy at 2.00pm. He went to the chaplaincy as requested, and both chaplains spoke to him together. The chaplain gave brief details of the morning's telephone call from his partner and allowed him to make a short telephone call to her. The chaplain wrote in his statement to the Governor that the man and his partner were both upset. He became angry, but then calmed down and told his partner that he loved her and would be there for her when he was released from custody.

173. After the call, the man asked for a few minutes on his own for a cigarette. Then the chaplain spoke to him again and the co-ordinating chaplain took him to the chaplaincy lounge for a drink and cigarette. The co-ordinating chaplain returned to check on his colleague, then went back to the man for another long conversation.

174. The chaplain initially suggested that the man could try to work with social services. However, he realised that the situation was more complicated as he disclosed that he had been in breach of a bail condition when he lived with his partner before coming back to prison. The co-ordinating chaplain wrote in his statement to the Governor that the man was tearful, but his mood improved and he spoke of moving on and making a fresh start. Eventually the man calmed down, and at 4.00pm he asked to return to the wing.

175. The chaplain wrote that the man asked to return to the wing, saying that he was okay and was sure that the relationship would continue. The chaplain asked him if he felt he should be placed on ACCT. He wrote in his statement that the man was emphatic that he should not go on ACCT and would speak to the Senior Officer or the chaplaincy if he became more depressed. The observation book records that the chaplain brought him back to the wing at 3.45pm, although his own statement records the time as 4.10pm. The chaplain wrote in the observation book that the man was very upset but calm. He added that he "did not feel that it is necessary to place [the man] on ACCT but staff may wish to 'keep an eye on him' over the next day or so". In

interview, he said that he did not expect staff to make extra checks on him, but thought that they would speak to him in the course of their usual routine. His assessment was that the man was “calm, collected, stable and able to continue”, and that no extra monitoring was required as he had promised to seek support from wing staff.

176. The man’s friend knew of the telephone call between the man and his partner. He tried to cheer him up and said this was effective for a while.

177. The chaplain informed the SO of the man’s news. The SO recorded in his wing file and the G wing observation book that the chaplain said that the man was not to have any contact with his girlfriend. The chaplain told her that the information came from the probation officer, but the SO was aware that prohibition of contact must be on the authority of the Governor. The chaplain told the SO he would complete a security information report (SIR), and she telephoned the public protection unit to ask for advice. (In interview, the chaplain confirmed that he had forgotten to complete the SIR.) The SO said that they did not discuss re-opening the ACCT document. She felt that, as the man had been with the chaplain, he would have a better understanding of his frame of mind and would have said if he felt it was necessary to re-open ACCT.

178. Later that evening, another wing officer escorted the man and three other prisoners to the chaplaincy to attend a prisoners group. The officer overheard the man tell the others about the possibility of the children going on the at risk register. The officer thought that he was upset, but accepted and understood the situation.

179. The man talked to the chaplain about how much he loved his partner and her children. But if they had no future together, he said he would start again. The chaplain thought he was in quite good spirits and again promised his support. They spoke again about 15 minutes later when the chaplain said that he was worried and wondered about opening an ACCT document. The man assured him that he was fine and did not need to go on ACCT. They spoke about the support that was available and the man shook the chaplain’s hand (which was his custom), saying that he would see him on Sunday. The co-ordinating chaplain also saw the man and noted that he seemed composed. As the man left the chaplaincy at 7.30pm, the co-ordinating chaplain saw him give a thumbs up sign and say thank you.

180. The man and his friend talked together during the evening. His friend knew that the man was unhappy about social services’ comments about his partner’s children. He said he reassured him that the children would not be removed whilst he was in prison as they were not at risk. Whilst they were talking together, the man’s friend noticed a plant in his cell and the man told him how he liked to look after it.

181. As usual there was a duty governor on duty that evening and she carried out the routine checks of the wings. She noted the previous comments in the observation book and discussed them with the wing SO on duty that evening.

(The SO was not the one who had been involved with the man's ACCT reviews, but she did know him from her routine wing duties.) The duty governor noted that ACCT was not considered necessary, but that staff would observe the man over the evening duty and record their observations of his actions. (There are no records of any observations in the observation book.)

182. The SO talked to the man at 7.30pm and recorded that he said he was alright, but wanted to have the following day off work. She agreed to his request. In interview, the SO described him as a quiet prisoner who was not afraid to approach staff and discuss an issue. She had known him during his previous sentence when she was aware of his financial difficulties. He would ask her to check letters he had written and she commented that he was an articulate letter writer. He mixed with other prisoners and was not isolated.

183. The officer who took the man to the chaplaincy earlier saw him again in the evening and noticed that his eyes were red from crying. She knew that he had talked to the SO and thought that she was dealing with any issues. The officer gave a verbal handover to the OSG who was on duty again overnight. In interview, she said she drew the OSG's attention to the entries in the observation book about the man and signed the book to that effect. She noted that there were 189 prisoners, four of whom were on Bullying Incident Reports (BIRs) but none on ACCT. She wrote that there were no other issues apart from the man. The OSG confirmed the handover by signing the observation book below the officer's entry.

184. The OSG recalled being asked at the beginning of the week (but could not specify the date) to look at the man every two hours or so, but said he was not told the reason for the additional observations. In interview for this investigation, the OSG said that he made the observations as requested but did not record them. No incidents were recorded in the observation book during the night and the OSG handed over in the morning.

Wednesday 23 May

185. The CALM tutor, replied to the man's complaint on 23 May saying that she had been able to trace the application made in his previous sentence and he did not need to repeat it. He could go on to the waiting list for the next course which was due to start at the end of July.

186. The workshop instructor wrote in his statement that he talked to a number of G wing prisoners during the afternoon. They told him that they would be surprised if the man came to work during the rest of the week as his partner had jilted him.

187. The man had another appointment (his eighth) with the counsellor at 3.30pm, and another wing officer unlocked his cell so that he could attend. The officer did not notice that anything was the matter with him.

188. As the man walked towards the counsellor, she thought that he seemed extremely distressed. She asked him what was the matter, to which he replied

that he “had good reason” as he had been told that he could no longer have any contact with his partner and her children. He had a good family visit on Monday, but his partner had told him that social services were coming to see her as they had been contacted by the probation service. The man told the counsellor that he had been told at the chaplaincy the previous day that his partner’s children would be put on the At Risk register if she had further contact with him. He said that her telephone number was being removed from his approved list and they would have no more contact.

189. The man told the counsellor that he had been crying ever since he got the news. He asked to terminate their session after half an hour. The counsellor advised him that she was concerned about his state of mind and would speak to wing staff. He composed himself and, as he made his next appointment, he remembered the questionnaire and said he would return it then.

190. The counsellor immediately went to the wing where she spoke to the second wing SO. The SO said that a letter had just arrived for the man which she intended to take to him and would keep an eye on him during the evening. (The counsellor thought that a letter had just been delivered to the man.) The counsellor said that she raised the recent closure of the ACCT document with the SO, wondering if it should be re-opened. She was advised that the man would be seen.

191. The counsellor also left a message for the volunteer co-ordinator, asking her to contact her as soon as possible. The counsellor subsequently reported to the co-coordinator that the man had asked to end the session early, saying he hoped she did not think he was rude in making the request.

192. The man and his friend talked again at about 4.30pm when the man went to his cell during association. His friend thought that the man was upset as his partner had written to end their relationship. The man left briefly, returning with the plant his friend had noticed a few days earlier. He gave the plant to his friend, saying that it had his partner’s name and he did not want it any more as the relationship had finished.

193. The observation book states that the SO talked to the man towards the end of the afternoon at 4.45pm. She had discussed him with the duty governor beforehand. The man told the SO that he was alright, and that he had to accept what had happened with his partner and move on. He asked to miss work the following day because he was afraid that his concentration might slip. The SO agreed and told him that his cell could stay unlocked whilst the cleaners were carrying out their duties during working hours.

194. The man’s friend saw him in the exercise yard at the end of the evening before they were locked in their cells for the night. The man approached his friend and showed him the letter from his partner. His friend tried to reassure him again, after which he thought the man was more positive and they chatted about other matters. The officer who had previously completed the CSRA also spoke to the man whilst he was in the yard and asked how he was. He told her that he was fine and she did not think that he appeared to be upset.

195. The SO recorded that the man said he was not suicidal, but staff should be aware and monitor him over the next few days. She said that she did not think he was suicidal as he was laughing and joking. She wanted staff to look for any change and, if necessary, place him back on ACCT.

196. Another officer was on duty. She remembered the SO saying that she was going to talk to the man again in the morning. The officer carried out the evening roll check at about 8.00pm. She told the police that she remembered him standing at his sink, washing his hands, and did not notice anything unusual about him or his cell. The officer said that she spoke to the man, who replied, and continued the remainder of the check. The SO also spoke to the man and he told her that he was alright. She did not think that he was upset and so talked to him on the landing rather than in private. She asked him how he felt and he told her that he had to accept what had happened and move on. The SO felt that he was dealing with the relationship ending.

197. The observation book was checked again by both the orderly officer and the duty governor who wrote that "night staff be aware of (the man)". The same OSG returned to duty that night and again signed to confirm that he had received a handover briefing. In interview, the OSG said that he was not briefed about any specific concerns and no prisoners were on ACCT.

198. The OSG carried out the evening roll check and began the pegging routine at about 10.00pm. Loud music was coming from cell 2.52, a few doors away on the same landing as the man's (which was 2.44), and other prisoners were complaining about the noise. The OSG told the prisoner to turn the noise down, and said that racist comments and threats were made in response.

199. The prisoner rang his bell and kicked his door, but then quietened down until 11.30pm when he rang the bell at the same time as the SO arrived. The SO spoke to the prisoner, who was again abusive and broke a bottle, threatening to use the glass to cut his throat. The SO sought advice from the duty governor, and two officers and a nurse were asked to come to the wing. Eventually, the duty governor decided that the prisoner should be moved to the segregation unit.

Thursday 24 May

200. The prisoner who had been making the disturbance was moved to the segregation unit at about 4.00am. The OSG said that the prisoner was bleeding and drunk when he left his cell, and the landing lights were off. Afterwards, the OSG began the paperwork arising from his part in the matter. He said that he began the morning roll check at about 5.45am, by which time it was daylight and the wing was quiet. He was thinking about the outstanding reports and that the night's events had to be written in the observation book. When he reached the prisoner's cell, he noticed that there was blood and broken glass on the landing floor leading in the direction away from the man's cell. The OSG said that he made a mental note that it would have to be cleaned up, and continued with the roll check.

201. When the OSG reached the man's cell, he opened the observation panel and saw that it was obstructed. He said that he kicked the door, rather than knocking, using his hand to open the panel. He said that he did not speak and only made the noise from his kick which would have been equivalent to that of a knock on the door. He said that the light at the time was dull and he did not look through any other part of the door. He heard a response and continued with the rest of the checks. The OSG was unsure what the response sounded like, acknowledging that he was thinking about the rest of his duties but confirmed that it sounded like speech rather than an inanimate sound. (The prisoner in the cell next door to the man subsequently told the police that he heard the night officer shout to him to uncover his flap and open the door.)

202. The OSG completed the check, handed over the records and made the entry in the observation book. His shift finished and he left the prison after the day staff arrived.

203. The officer who completed the CSRA came on duty again at 6.55am on 24 May. As she came through the gate, she was informed of an incident during the night which had resulted in the prisoner being removed to the segregation unit. She was told that there was blood and glass on the floor and she should decide whether external cleaners were required. The officer reached the wing about ten minutes later and the OSG gave her a handover, which she described as normal except for the incident. No reference was made to the man.

204. The officer began the morning cell checks at 7.05am, and said that the light was bright. She checked each prisoner by opening their cell observation panel, switching the light on and checking that they were alive and well. As she approached cell G2-44 five minutes later, she could see through the gap between the door and the frame that a barricade appeared to be in place. She saw that the bed frame was standing upright against the door and then opened the observation panel. The panel had been obstructed and she called out twice, but got no response.

205. The officer used her radio to contact the control room and ask for assistance. The call was passed to a Principal Officer (PO) who said that he would make his way to the wing. He had come on duty that morning and was the orderly officer (Oscar 1) in charge of the prison's operations. (The PO is also Risley's suicide prevention co-ordinator.) The PO asked the officer to try to get a mirror to slide between the door and the frame, thinking that the prisoner might hit it which would help him know what he was dealing with.

206. The PO met the officer as he walked up the stairs to the landing at 7.20am. He told her to telephone the gate office to send the next four staff on duty to the wing whilst he removed the anti-barricade plate from the door. He did not want her to use her radio from the landing as he did not want other prisoners to be alerted. The PO also asked the officer to arrange a cell in the segregation unit and ask healthcare to attend. He spoke through the door, but did not get a reply. He then began to remove the bolts from the door, and

used his radio to repeat the request for more staff to attend. The mattress was visible through the side of the door and nothing could be seen through the observation panel.

207. Another officer was on duty on F wing at 7.15am when he received a telephone call from the first officer to ask for assistance. The first officer told him that the observation panel of cell G2-44 was covered and she believed that there was a barricade behind the door. She said that she had failed to get a response from the occupant and, as the other officer was a trained negotiator, she thought he might be able to deal with the situation. (The second officer is also a first aid instructor who holds an up to date first aid qualification.) The second officer told his colleague to inform the control room and ask the orderly officer to attend. He said that he would get someone to relieve him on F wing and come as quickly as possible.

208. At approximately 7.25am, a third officer and the SO who had been on duty the previous evening arrived at the prison. They were told that a prisoner had barricaded himself in his cell on G wing. They went straight to the wing, where they found the first officer and the PO, and advised that the man was not a troublesome prisoner and he would not attack them. The third officer could not see through the observation panel which was blocked. He is over six feet in height, considerably taller than the PO, and was able to look through the crack at the top of the door. He saw that the bed was upright and he attempted to open the door. The door was barricaded and the officer pushed it so that it opened about 12 inches. The third officer saw that the man was hanging from the upturned bed. He told the PO that the man was hanging and that immediate assistance was required.

209. Whilst the third officer was attempting to open the door, the PO had opened the block on the door so that it could be reverse opened outwards on to the landing. They went in together and saw the man hanging with his legs on each side of his chair. The PO supported the man’s body whilst the officer used his fish knife to remove the ligature and laid him on the floor. (The knife is shaped like a fish and is designed to be inserted safely between the neck and any ligature.) The officer said that the SO moved the chair away. The man’s body was stiff and his hands and face were blue, with his tongue protruding. The PO said it was immediately apparent that the man had died, but he was not qualified to make a decision. He began to create enough space for cardio pulmonary resuscitation (CPR) to begin.

210. The second officer was relieved on F wing at 7.25am and went straight to G wing where he found the third officer outside the cell comforting the SO. The third officer told him that the man was hanging from his upturned bed frame and was dead. The third officer went inside the cell and saw a lot of blood on the right hand side of the cell. He checked for signs of life but the body was cold and in the early stages of rigor mortis. He saw the mark of the ligature round the man’s neck, but there were no wounds there.

211. At 7.28 am, a nurse (who happened to be the one who treated the man after he took the overdose) was in healthcare and was allocated as Hotel 1 (the

duty healthcare nurse). She received a call to attend G wing immediately. The message did not give any information about the type of incident. She did not know what equipment was required and took a basic first aid kit with her. At the same time, one of her colleagues telephoned the control room and was told that the incident concerned a prisoner's barricade. The nurse did not think it was as serious as she first thought. The Healthcare Manager telephoned the wing to be told by the SO that there had been a death. The manager and a second nurse followed the first nurse to the wing, taking the defibrillator with them.

212. When the nurse reached the wing, she passed an officer who mentioned that it was "too late", and then saw the SO and the first officer, who she thought were upset. The nurse arrived at the man's cell. Two officers were outside and the door was ajar. She was told that the prisoner had been found hanging and had been cut down by staff. The nurse said that she needed to go inside the cell and the second officer accompanied her. She saw the man lying on his back with his head towards the window and noticed a deep and wide indentation round his neck from the ligature. Her first impression was that there were no signs of life. The nurse saw that his eyes and mouth were open and his tongue was visible. The lower part of his face was discoloured and his arms were raised slightly from the floor. She felt that his body was stiff and cold.

213. As the nurse checked the man's vital signs, she noticed fresh blood on his right wrist which came from a wound there. She could not detect a pulse and so checked his eyes but got no response. She concluded that the man had died and made no attempt to administer cardio pulmonary resuscitation (CPR). The nurse noticed that the cell had no personal belongings on display and a couple of brown boxes were piled neatly by the sink. The officer asked her where the blood had come from, and then noticed a knife made by inserting a razor blade into the melted handle of the razor. He asked for an evidence bag in which he placed the ligature and knife. They left the cell and the nurse said that she checked the welfare of the officers and briefed her healthcare colleagues who had arrived. They waited on the wing for the paramedics to arrive.

214. The PO knew that the duty governor was not yet at the prison and so delegated another SO to remain on the wing whilst he went to the communications room to begin implementing the prison's plan for dealing with a death in custody. He and the communications staff continued working through the plan until the duty governor's arrival.

215. The ambulance was called at 7.30am and the chaplaincy at 7.40am. The duty governor arrived at 7.45am and took over implementation of the plan for dealing with a death in custody. The PO briefed the duty governor and was then relieved of the Oscar 1 duties. The PO took over his suicide prevention co-ordinator's role and arranged for all the prisoners on ACCT to be reviewed.

216. The paramedics arrived at 7.50am and the second officer unlocked the cell so that they could go inside. The nurse was present when their tests confirmed

that the man showed no signs of life. The paramedics left the cell which the officer locked again. He waited outside until the SO who had been briefed and a third SO began to keep a log of events. The nurse returned to the treatment room. One of the chaplains attended and said the last rites, after which an SO locked the cell again at 8.00am.

217. Other prisoners on the wing were checked at 8.12am and again throughout the morning, with special attention to one who was on an open ACCT. One of the prisoners said that support was offered after the man died, but little information was passed on at the time. He thought that the other incident during the night had led to a mood of uncertainty amongst prisoners. The man's friend, who he gave the plant to, said that his friends were not given any special treatment, although a governor and member of the IMB were available to all the prisoners. In interview, the friend suggested that the man might have benefited from being moved to a shared cell and having someone to talk to after his relationship came to an end.

218. The coroner's office was notified at 8.15am. The chaplain was contacted at home and notified of the man's death.

219. A member of the IMB, arrived at the prison at 8.20am and then went to G wing where he remained until 2.35pm. He was joined by another member and the IMB chair, and together they observed staff attending to their duties. The IMB members made themselves available for any staff and prisoners who wished to speak to them.

220. The prison doctor was telephoned at about 8.30am before he arrived at the prison, and told that the man had hanged himself. The doctor told the police that he was shocked and described it as a tragic event. He thought that the man was an impulsive person, and that this was an impulsive act.

221. The duty governor handed over to the Deputy Governor, and she in turn handed over to the Governor when he arrived at 8.45am. At the same time, prisoner's pinphones were checked and cut off so that no information could be passed on before the next of kin had been notified. Other than those with visits or who were wing cleaners, prisoners were not unlocked as usual during the morning, but remained in their cells where their meals were served to them. The Governor commented that prisoners were very cooperative and no cell bells were rung whilst they were locked up.

222. The cell was unlocked at 9.00am so that the doctor, who was accompanied by the Head of Healthcare, could examine the man. The doctor checked for signs of life and pronounced at 9.00am that the man had died. In his statement to the police, the Head of Healthcare noted that the cell television had been switched on. The SO sealed the door afterwards.

After the man's death

223. A second contact was made with the coroner's office at 9.00am, and information provided that the police would take responsibility so that the coroner's officer would not attend. The police were informed, arriving at 9.40am to take charge of the cell and gather photographic and forensic evidence.

224. The man was formally identified at 9.56am by the second officer, after which the cell was searched. The ligature, a home made bladed weapon and some letters were removed.

225. Another governor, who was a trained family liaison officer, and the prison's police liaison officer, were asked to contact the man's family to tell them of his death. Although the man had named his partner as his next of kin, knowing about the relationship difficulties, they decided to go first to his father's home. The prison log records that they arrived at 11.05am, but got no reply and were told by neighbours that he had been away for a few days. They decided to go to the man's partner and arrived at 11.30am. She handed over two unopened letters to the governor, the first from the social services department and the second from the man himself.

226. Efforts to locate the man's father continued and a message was left at his home asking him to contact the prison.

227. The staff care team was available to provide support for staff. Those staff interviewed expressed their appreciation for that support, as well as that received from their managers and the IMB.

228. During the morning, the man's probation officer revised his OASys assessment and made follow up telephone calls. She telephoned the prison at 11.40am and spoke to the offender supervisor. At this stage, neither of them knew that the man had died. The probation officer reported that the man and his partner had fallen out and she was going to end the relationship. The probation officer told the offender supervisor that the letter might have already been sent, and she was concerned about how the man might take the news. The offender supervisor agreed to see the man and find out his reaction if he had already received the letter. She also telephoned the security department as she was concerned about the man's letters and telephone calls from his partner, and was asked to put her concerns in writing to the Governor. Shortly afterwards, whilst still completing the OASys document, the probation officer's colleague telephoned to tell her of the man's death.

229. After lunch was served to the prisoners, a notice was delivered to each cell to inform them of the man's death and offer support from the Listeners, chaplaincy or staff. Prisoners were also told that there would be association during the afternoon on the wing and they would not be required to work. The duty governor described the atmosphere that afternoon as good and said that prisoners were generally in good spirits.

230. As the police forensic examiner was delayed, the removal of the man's body to the Royal Liverpool Hospital could not take place until 1.10pm. The post mortem confirmed that death was due to hanging with significant blood loss. There was no suspicion of drugs and no letters were found. The man was fully dressed when he was discovered. The words "do not revive" were written on his chest. His right arm bore the words that he was sorry, together with his nickname for his partner.

231. An inter faith prayer service was held in the chaplaincy at 3.00pm, attended by 15 prisoners. The man was also remembered at the services the following Sunday, and the service sheets displayed his photograph in naval uniform. Prayer cards, also mentioning him by name, were provided for prisoners' use.

232. The police visited the man's partner the following day and she handed over a letter from him which had been franked by Risley on 23 May. The police officer described the letter as blood stained.

ISSUES

Personal officer duties

233. Risley's procedures for personal officers were prepared some years ago and have fallen into disuse. They predate the introduction of offender management and the close links now in place between offender supervisors in the prison and offender managers in the community. It was apparent in this investigation that the man's personal officer had been allocated for a short time and knew little about him. He was not expected to be responsible for specific tasks, such as cell sharing risk reviews, nor take any special role in implementing ACCT or have a general knowledge of the prisoner's life in custody.

234. I understand that the role of the personal officer is being reviewed, and so make no formal recommendation. The Governor may wish to consider these comments in the course of the review. As far as is practicable with shift patterns and extra duties, I suggest that personal officers should carry out all tasks for individual prisoners such as CSRA reviews and ACCT reviews. It would also be helpful to clarify their links with offender supervisors.

Clinical care

Reception

235. The man went through the routine reception health screens at Liverpool and Risley. As usual, they were largely derived from information provided by the prisoner himself. As far as his eventual death in custody is concerned, there are three relevant aspects to his reception at Risley. First, his history of self harm was correctly identified but no details were provided regarding the number of occasions or the methods used and it appears that previous records were not retrieved. Secondly, a timely referral was made to the mental health services and, although it was not classed as urgent, an initial appointment was offered just over two weeks later. Thirdly, the healthcare nurse concurred with the decision to allocate him to a single cell. His location was at his own request because of what were referred to as anger management issues. However, in spite of the man's self harm history, there is no evidence of a risk assessment taking place.

Medication

236. Soon after the man arrived at Risley, he caught a cough and cold and referred himself to healthcare. The clinical reviewer has assessed that the advice and treatment were appropriate, and Brufen tablets were prescribed because the man was allergic to paracetamol. However, in spite of his known history of self harm, he was given two prescriptions for a 28 day supply of the tablets without any evidence of a risk assessment about his ability safely to hold the medication in his own possession. Furthermore, there is no evidence of a risk assessment being carried out after he took the overdose even though the ACCT review listed it as an action point.

The Warrington Primary Care Trust and Five Boroughs' Mental Health Partnership should review the operation of the medication policy, in respect of prisoners holding their own medication, and ensure that each prisoner is risk assessed before medication is given to them and after any incident of self harm.

Mental health

237. The clinical reviewer's opinion is that the nature and severity of the man's mental health was correctly assessed and appropriate plans were made. On the basis of the reviewer's knowledge and the advice he received, he endorses the assessment that he was suffering from mild depression, accompanied by anxiety. He was not considered to need medication to manage a mild illness, but instead needed support to improve his social and problem solving skills.

238. As far as healthcare is concerned, the man was ably supported by the mental health worker, and then appropriately referred to the doctor and mental health nurse after he took the overdose. Their goal was to help him come to terms with being in prison and manage his relationship with his partner. The reviewer considers that the mental health worker's contribution to achieving these goals was comprehensive, but that they would have been enhanced by more effective monitoring which included timescales being set and the outcome reviewed.

239. I was pleased to find that the mental health team has a robust system for following up prisoners who miss appointments. They are notified of the time and date of their appointment in a private envelope, which is delivered by a nurse directly to the prisoner or to be passed on by an officer. If any appointment is missed, another is sent in the same way. In the event of a second appointment being missed, and the prisoner being of particular concern, the mental health worker would go to the wing to see them. Alternatively, a telephone call would be made to the wing to follow them up. This system worked in this man's case. Each time he missed an appointment, a follow up was booked.

Record keeping

240. On 22 May, the man's probation officer learnt that he had attempted suicide in April. She telephoned the Deputy Head of Healthcare who confirmed the information. The clinical reviewer has interviewed the member of staff concerned who has acknowledged that neither the fact, nor the contents, of the telephone conversation were recorded. As it happens, staff throughout the prison were already aware that the man was at risk, and so the omission was not critical. I make no recommendation, although the Primary Care Trust may wish to review the matter. Omissions such as this could be of critical importance in other situations.

Response to hanging

241. Unlike many other prisons, Risley does not use a system to distinguish between different types of healthcare emergencies. When the man was discovered hanging, the nurse on call heard the radio alarm and had to make a telephone call to ascertain what was required and the sort of equipment she needed. Fortunately, the line was clear and she was told that she was attending a barricaded cell. She did not regard the situation as life threatening, and only took a first aid kit with her.

242. A second radio call was made for healthcare and, as it was during the day, the nurse's colleagues were on duty in healthcare. They too made a telephone call. They were told that a prisoner was hanging and so gathered the appropriate emergency equipment to take to the cell.

243. In the event, by the time the man was discovered, it was too late for any of the interventions to be of any use. In other circumstances, it might make the difference between life and death.

The Governor and Warrington Primary Care Trust should review the arrangements for notifying healthcare of emergencies and consider introducing codes to indicate the type of emergency.

244. The clinical reviewer had made a number of other recommendations to the Primary Care Trust, which are not directly linked to the circumstances of the man's death. They include:
- improving record keeping
- provision of first aid kits on the wings
- benchmarking the performance of the mental health team
- assessing healthcare against Standards for Better Health.

These recommendations have been addressed in a separate letter to the Primary Care Trust.

ACCT

Assessment of risk

245. Most staff, including those working in healthcare, consistently assessed the man's risk of self harm/ suicide (other than when he was on ACCT) as low. The assessments were carried out by a range of professionals, including wing staff, mental health workers, the prison doctor, general nurse and Accident and Emergency staff.

246. Although the clinical reviewer thinks that the healthcare assessments were appropriate, he comments that a prisoner's risk should be assessed according to their circumstances and situation. For example:
- Healthcare knew that the man was supported by wing staff and the chaplaincy, but did not take their knowledge into account.

- The implications of his workplace were not considered. He was taking a joinery course, working with potentially hazardous equipment and needing to concentrate to remain safe.
- The man was not reassessed after he took the overdose.
- He remained in the same single cell, which was not a safer cell, throughout.

ACCT reviews and action plans

247. After the man took an overdose of tablets about four weeks before his death, the ACCT document was opened and reviewed in a timely manner in accordance with ACCT guidance. However, those attending the reviews (the wing senior officer and chaplain) were limited in their roles and their knowledge of the other support provided for him. It would have been good practice to involve other staff, such as the mental health worker, counsellor and workshop instructor. Even if they were unable to attend, they could have provided written comments.

248. The clinical reviewer recognises that healthcare staff did not have a central role in the ACCT process in relation to observations, reviews or closure of the documents. As the review states, it seems odd that, even when a prisoner is known to mental health services, there is no express requirement to seek their opinion. A prisoner's mental health must surely be relevant to their risk of suicide and self harm and it is difficult to understand why they are not routinely involved. The contribution of their expert advice and knowledge of the individual can only be of benefit in assessing the prisoner on ACCT.

249. The action plans prepared at each of the man's ACCT reviews were largely passive and, other than varying levels of observations, mainly included items such as remain in a single cell, and have access to the Samaritans telephone and Listeners. The only active suggestions were to organise a supervised family visit and request a psychiatrist's assessment.

250. This type of action plan might be appropriate in many situations, but in this case, given the number of professionals involved, I cannot help feeling the plan could have been more proactive. As the clinical reviewer has commented, an observation regime is not an end in itself. It should be used to safeguard the person whilst allowing time for therapeutic interventions to have an effect. It is especially important for prisoners with a history of mental illness who are on ACCT that there is a clear connection between the observation regime on the wing and workshops, and the therapeutic regime provided by the mental health worker, chaplain and counsellor. Not including these other professionals in ACCT decision making was, in my view, a missed opportunity.

251. The decision to close the man's ACCT document on 8 May was based on the improvement in his mood at the beginning of the month and his statements that he was giving the relationship until his birthday, seven days later, to see whether it had a future. The SO and chaplain were both confident that his resources were sufficient to enable him to overcome any difficulties. Although other staff were not present when the ACCT was closed, no-one asked for it to

be reconsidered. (The mental health nurse told the clinical reviewer that she believed that the man's mood had genuinely improved as he was looking forward to his partner's visit.)

Information sharing throughout the prison

252. In many respects, information about this man was widely shared, but there were significant oversights that should be addressed.

253. Although there is evidence of various professionals working well together on a day to day basis, much of the information sharing relied on his own willingness to disclose. For example, the counsellor's contract requires her to report any information about risk to prisoners, but there is no parallel expectation that the prison will inform her of such matters. Fortunately, the man was willing to disclose the support he received, and share the fact that an ACCT document had been opened. Other prisoners might not be so open, which could mean that a counsellor might inadvertently interfere with objectives agreed with other parts of the prison.

254. Another gap concerns information sharing about ACCT documents. Although mental health workers know when ACCTs are opened (although not when they are closed), other healthcare staff are not always aware. The same applies to staff from other disciplines. For example, the joinery instructor and offender supervisor only knew that the man was on ACCT, and the counsellor only knew of the mental health worker's involvement, because the man himself shared the information.

255. The workshop instructor's statement to the Governor notes that, whilst the ACCT document was open, the file did not consistently accompany the man to the workshop. When the document did arrive, it was delivered late and collected early, meaning that there was insufficient time for reading or recording.

256. The clinical review says that very little information is exchanged between the healthcare and psychology departments. When a patient with mental health problems receives counselling from the prison, at the very least the mental health service should be aware of the fact and of any relevant significant issues which the counselling is seeking to address.

The Governor, Primary Care Trust and Five Boroughs' Partnership should work together to involve all practitioners in the implementation of ACCT for prisoners who are known to them.

257. The clinical reviewer has commented that healthcare staff would welcome a clear statement of their role in relation to ACCT, and the same applies to other parts of the prison. In interview, both the Head of Healthcare and the prison's doctor acknowledged that they do not contribute to safer custody meetings, something which is undoubtedly a source of frustration for the safer custody manager. The active participation of healthcare in the safer custody strategy would have benefits when it comes to the casework involved at an ACCT

review. Healthcare staff are not routinely nominated for ACCT training, although I was pleased to note that the man's mental health worker, workshop instructor and counsellor had all been trained.

The Governor, Primary Care Trust and Five Boroughs Partnership should ensure that all departments are actively involved in the prison's suicide prevention strategy.

Decision not to open ACCT on 22 May

258. The clinical reviewer carried out a helpful analysis of the research into suicides in prison. He found seven characteristics typical of those who engage in suicidal behaviour, of which two may have applied to this man. They were his inability to make good interpersonal relationships (as evidenced by assaults on his mother and partner) and his low self esteem (derived from his experience of childhood abuse). The other factors (poor upbringing, social and economic disadvantage, alcohol and drug addiction, poor educational attainment and employment history, and weak problem solving ability and low motivational drive) were less apparent. (Although in respect of alcohol, see paragraphs 11 and 68 above.)

259. The reviewer found that the man was in a minority in having good academic qualifications and no history of social exclusion. However, his health status was more typical in that nine out of ten prisoners have at least one mental health disorder, including anxiety/ depressive disorders.

260. The key factor to the man's risk of suicide and self harm was the relationship with his partner. Whether they were party to the ACCT decision making or not, all the staff involved shared his own opinion that the relationship was fundamental and they were aware of his vulnerability. Likewise, all knew when the relationship was at risk and when it came to an end. Almost all were persuaded that the man was motivated to move forward with his life. Those, like the counsellor, who thought that ACCT should be reopened were content to leave the decision to wing staff.

261. I think it is telling that the man was described by all as someone who liked to be in control of his life, and who did not cope easily when things did not go according to plan. In that light, re-opening the ACCT when his major ambition was circumvented would have been a sensible precaution.

262. A prisoner's denial of thoughts of suicide or self harm should be only one factor to be taken into account when deciding whether to open an ACCT document. The prisoner's words may not be conclusive and should be supplemented by appropriate observations and vigilance. The man denied any thought of harming himself, but everyone knew that the state of his relationship was critical to his state of mind. That the end of the relationship would have a catastrophic effect could, and possibly should, have been foreseen.

263. I trust that implementation of my recommendation concerning the involvement of all practitioners in the implementation of ACCT will help to address the deficiencies highlighted here.

Roll check 24 May

264. The observation panel of the man's cell was first found to be obstructed during the morning roll check which was carried out by night staff. Although the member of staff admitted that his mind was on other matters at the time, he gave initial assurances that he had heard a response from within the cell. Having heard what he described as a person making a response, the member of staff took no further action regarding the obstruction. It was next seen at the following check, about an hour and a half later, when the officer responded as she was expected to. The outcome was the discovery of the man hanging from his up turned bed.

265. It is not within the competence of this investigation to determine when the man died and whether he could have been saved if he had been found at the first check. However, I should say that I am entirely satisfied with the action taken by the Governor when he realised what had happened. Within 24 hours of his death, all staff had been reminded of the importance of carrying out proper checks. When further information was passed on from the prisoner in the neighbouring cell, the Governor commissioned his own investigation and suspended the OSG, who has since resigned.

CONCLUSION

266. Unlike many of my investigations, the young man at the heart of this one was very well known to staff of different disciplines within the prison, and was supported by many of them. The man was preoccupied to the point of obsession with his relationship with his partner, and openly discussed his thoughts and feelings with his friends, as well as seeking support from staff. All concerned recognised that the relationship determined his moods. It was his explanation for the overdose and the reason the ACCT document was closed. Judging by the words written on his body, it was also the reason why he took his life.

267. There were some failings with the formal information sharing arrangements, notably when the ACCT documents did not accompany him around the prison. However, there were many other examples of good links, especially between the chaplain and the wing staff who worked closely together whilst the ACCT was open.

268. The ACCT arrangements would have benefited from including the opinions of all who supported the man. Consulting the mental health worker, counsellor and workshop instructor might not have changed the decision to close the ACCT on 8 May. However, had those professionals attended ACCT reviews and been consulted after his relationship broke down, it is possible, perhaps probable, that the ACCT would have been reopened. My own view is that the ending of the man's relationship with his partner, coming as it did within weeks of his suicide attempt, should have led to suicide and self harm monitoring and support being restored.

RECOMMENDATIONS

The Governor and Primary Care Trust should:

1. Review the arrangements for notifying healthcare of emergencies and consider introducing codes to indicate the type of emergency.

   Since the publication of the draft report, I am pleased to learn that the Governor and Primary Care Trust have accepted the recommendation and are considering how to introduce emergency codes. The target date for completion is January 2008.

The Governor, Primary Care Trust and Five Boroughs' Mental Health Partnership should:

2. Work together to involve all practitioners in the implementation of ACCT for prisoners who are known to them.

   This recommendation has been partially accepted, dependent upon agreements between the agencies and the available resources. The target date for completion is February 2008.

3. Ensure that all departments are actively involved in the prison's suicide prevention strategy.

   The recommendation has been accepted and will be implemented by February 2008.

The Primary Care Trust and Five Boroughs' Mental Health Partnership should:

4. Review the operation of the medication policy, in respect of prisoners holding their own medication, and ensure that each prisoner is risk assessed before medication is given to them and after any incident of self harm.

   The recommendation has also been accepted and will be implemented by February 2008.

Good Practice

5. The chaplaincy is notified whenever an ACCT document is opened and one of the chaplains visits each ACCT prisoner every day.