Investigation into the circumstances surrounding the death of a man in July 2010 whilst in the custody of HMP Hewell

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of an investigation into the death of a prisoner at HMP Hewell who died on 9 July 2010. In March 2010, the man attempted to take his own life by tying a ligature to the bars of his landing. He was subsequently placed on the prison's self-harm monitoring and support procedures. Although they were closed when the risk reduced, staff re-introduced them just over six weeks later, on 22 June, when the risk increased again. The procedures were still in place when, on 9 July, the man was found hanging in his cell. He was taken to a local hospital where he was pronounced dead. He was 46 years old.

I would like to offer my sincere condolences to the man's family and to all those affected by his death. I am sorry that my report has been delayed and regret any additional distress which this has caused.

The investigation was undertaken by my colleague Mr Rob Del-Greco. I would like to thank the Governor of Hewell and his staff for their assistance during the investigation. A clinical review into the man's medical care at Hewell was commissioned from Worcestershire Primary Care Trust. They appointed a doctor to conduct the review, and I am grateful for her report.

The clinical reviewer concludes that the man's clinical care was comparable to what he would have received in the community. I endorse two of her recommendations concerning the maintenance and use of defibrillator machines and ensuring information is fully recorded in medical records.

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

Jane Webb
Acting Prisons and Probation Ombudsman **July 2011**

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SUMMARY

1. The man was born in 1963. He was 46 years old when he died on 9 July 2010 in hospital. The man had been found by staff during the morning. He had attached a ligature to the back of the toilet door in his shared cell.

2. The man was remanded into custody by a Magistrates' Court in September 2009. He transferred to HMP Hewell on 29 January 2010.

3. During the man's first reception health screening interviews, it was recorded that he had previously had surgery for a perforated stomach ulcer and was awaiting an appointment for an operation for a hernia. The man was a smoker and assistance to help him stop smoking was offered. He chose not to take up the offer.

4. On 18 March, the man jumped from the second floor landing after tying a ligature to the railings and then placing it around his neck. Staff responded immediately and, after treatment at hospital, he returned to Hewell later that day. As a result, a self-harm observation and support regime was started which involved regular checks being carried out and recorded. The procedures were stopped on 5 May, when the man appeared to have accepted his situation. They were started again on 21 June, after concerns were again raised by staff about the man's well being.

5. During the morning of 9 July, the man's partner contacted Hewell after she received threatening telephone calls from him. Later that morning, when staff escorted his cell mate back to their shared cell, they discovered the man hanging from a ligature attached to the back of his toilet door. After starting cardio pulmonary resuscitation, they asked for further medical assistance and an ambulance was also called. After paramedics carried out an assessment, the man was taken to a local hospital. The initial security risk assessment concluded that restraints were not to be used and he was to be escorted by two officers. Despite extensive efforts to resuscitate the man both at the prison and hospital, he was pronounced dead by a hospital doctor at 11.56am.

6. The clinical review carried out by a doctor on behalf of Worcestershire Primary Care Trust considered the care provided for the man. In the clinical reviewer's view, the quality of care given to the man was equivalent to what he would have received in the community. The clinical reviewer makes two recommendations for service improvement which I endorse. I understand that the prison health partnership is considering the findings from the review and developing an action plan to address them.

THE INVESTIGATION PROCESS

7. My investigator was formally notified of the man's death on 12 July 2010. Notices were subsequently issued to both staff and prisoners at HMP Hewell to inform them of the investigation process and asking anyone who had information pertinent to my investigation to contact the investigator. No responses were received. The investigator also studied all the relevant prison records relating to the man. They included his main prison record and his medical records.

8. A clinical review was commissioned from Worcestershire Primary Care Trust into the care provided for the man during his time in custody. The purpose of this review is to establish whether the care which the man received in prison was comparable with that he would have been offered in the community and to identify any points of learning. A doctor was appointed to lead the clinical review. I am grateful for her review, although I did not receive it until 2 February 2011, and it is annexed to my report.

9. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

10. One of the Ombudsman's family liaison officers contacted the man's partner and daughter. They were informed about the purpose of the investigation and offered the chance to raise any concerns or questions that they wanted to be addressed. The investigator and the Ombudsman's family liaison officer later met the man's partner to discuss her comments further.

11. Through contact with the man's partner and daughter, the following matters were raised:

    - Some property was missing - this included letters from his previous suicide attempt and a card.
    - Why did staff not check on the man immediately following the telephone call from his partner on the day of his death? She was adamant that she mentioned both the threats to her and to himself to the member of staff at the prison who received her call.
    - Whether the level of monitoring of his risk of self-harm was appropriate especially as the difficulties in his relationship were known to staff?
    - Why his cell door was locked when he was by himself and subject to self-harm monitoring procedures?
    - Whether the level of staffing on the wing was adequate on the morning of his death.
    - His partner asked for further clarification as to the events on the morning of his death.
    - She spoke at length about the volatile nature of their 22 year long relationship and that it was not unusual for them to split up and get back together again.

- His partner also said that the man had been in prison in the past but had not been as paranoid as on this occasion.

The investigator has attempted to address the issues raised by the family within the report. I hope that this helps the man's family to understand the events leading up to the man's death. The solicitors representing the man's family received a copy of my draft report and commented on it. They wrote that it was unclear from the ongoing records what observations were actually undertaken on the 9 July. They drew attention to the man's interaction with the member of the Counselling, Assessment, Referral, Advice and Throughcare team on the day before his death. They queried why the man's observation levels and level of risk were not increased. They said it was still not clear whether the man's cell door was locked from the inside or outside. They were also still concerned about the actions taken by the duty governor on the morning of 9 July following her telephone conversation with the man's partner.

12. The investigator visited HMP Hewell on 15 July and spoke to the Acting Governor and the Head of Healthcare as well as other staff involved in the care of the man. He returned on 3 and 4 August and 14 and 15 September. The investigator to conduct interviews with staff. He also visited HMP Stocken to interview the man's cell mate and two other prisoners who had previously been held at Hewell. The investigator also met the Chair of the Independent Monitoring Board.

13. After completing the interviews, the investigator discussed the emerging issues with the Governor, on 15 November, and later confirmed his findings in writing.

HMP HEWELL

14. HMP Hewell was created on 24 June 2008 by merging three separate prisons which were located on adjacent sites (HMP Blakenhurst, HMP Brockhill [1] and HMP Hewell Grange). Hewell primarily serves the West Midlands, Worcestershire, and Warwickshire areas.

15. The new prison accommodates Category B, C, and D prisoners. There are seven house blocks, each divided into wings. House blocks one to six form the Category B prison and accommodate prisoners remanded by the courts, those awaiting sentence and convicted prisoners (including those sentenced to life imprisonment) to Category B status who are awaiting transfer to training prisons. Wherever possible, prisoners are allocated to a house block according to their categorisation.

16. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners in a locked cell which includes taking into account the situational context of any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a plan to minimise risk for those identified as high or medium risk which is reviewed at regular intervals.

17. Healthcare is provided by Worcestershire Primary Care Trust. The unit has 24 hour nursing staff, with in-patient care situated on the lower floor of the unit. All in-patients are encouraged to associate out of their cells, including eating in a communal dining area. There is a varied timetable of activities with nursing staff supporting patients to actively socialise together. A weekly multi-disciplinary meeting is held to discuss individual prisoners, both those who are physically and mentally ill.

18. The investigator reviewed the Ombudsman's reports into earlier deaths at HMP Hewell. He found no issues in common between the earlier deaths and that of the man.

Access to telephones

19. Pin telephones are used in prisons and each prisoner is given a PIN number which they key in before making a call. Prisoners complete a form to select telephone numbers for their family, friends and legal contacts, which has to be agreed by the prison. The system works on a credit basis and prisoners buy credit from the prison shop, the cost of the calls being automatically deducted from their PIN account.

20. Hewell's local procedures state that prisoners identified as potentially Category A are permitted normal access to PIN phones. Exceptional Risk Category A prisoners (which the man was not) are not given access to PIN phones.

[1] The Ministry of Justice closed the Brockhill part of the prison in September 2011. The closure formed part of wider-ranging cost saving plans by the ministry.

Insiders and Listeners

21. Hewell recruits experienced prisoners to operate as Insiders and Listeners. Insiders welcome new prisoners, highlight any concerns and explain the processes they will encounter in the early days of custody. Listeners assist those prisoners who require additional support at any time in their period in custody. They are trained by the Samaritans and provide confidential support.

Roll check

22. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur at specified times during the day, and staff must sign that the roll is correct. Hewell's local procedures state that roll checks should be carried out at 6.00am, 12.30pm, 5.30pm and 8.00pm.

Assessment, Care in Custody and Teamwork (ACCT)

23. The ACCT system monitors and supports prisoners who are assessed as at risk of suicide or self-harm. It is a flexible, prisoner-centred assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment. Once placed on ACCT, the prisoner is observed at intervals determined by their perceived level of risk. The observations continue during the day and the night. Additional support is offered from Listeners, personal officers and other staff. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner within a prison. The arrangements are reviewed regularly by a multi-disciplinary meeting, which includes the prisoner.

Independent Monitoring Board (IMB) Report

24. A prison's Independent Monitoring Board (IMB) is appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

25. The most recent annual report published by the IMB at Hewell covers the period from 1 December 2008 to 30 November 2009. The IMB drew attention to the positive approach taken by former Governor, Ms Alison Perry, with regard to the merger of the three former prisons. The IMB said: "The path of progression throughout the prison - *One prison, One vision* - is encouraging as is the continued consolidation of policies and protocols."

26. The IMB also said:

> "The Board notes that the ACCT/2052SH procedures are maintained at HMP Hewell. The inspection of records during Rota visits and observation of Houseblock routines indicate that care plans and case reviews are conducted in accordance with prison rules and protocols."

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

27. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes and offer counselling and support to prisoners. Access to the CARATS service is voluntary, by application of a prisoner.

HM Chief Inspector of Prisons report

28. The first inspection of HMP Hewell by the former HM Chief Inspector of Prisons, Dame Anne Owers, was in November 2009. In her introduction to the report of the inspection, Dame Anne said:

> "Managers had placed a commendable focus on safety, and most prisoners in the closed part of the prison reported feeling safe … The central reception was enormously busy, but professional and efficient. First night arrangements required development, specifically the new arrangements for Houseblocks 1-6. An innovative and effective approach was taken to violence reduction, use of force was relatively low, and the segregation unit was well managed."

29. In regards to the support of prisoners who are subject to ACCT procedures, Dame Anne said:

> "Suicide and self-harm prevention arrangements were generally sound, although access to Listeners was poor … The quality of assessment, care in custody and teamwork (ACCT) self-harm monitoring documents was mixed. Initial assessor reports and care maps were generally good, but case reviews were not multidisciplinary and monitoring entries were mainly observational."

Performance ratings

30. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four (one being "serious concerns" and four "exceptional performance"). For the last four performance reports, HMP Hewell has been given a rating of three (or "good performance").

KEY EVENTS

31. The man was born in 1963 in Birmingham. Prior to coming into custody, he was unemployed but had previously worked as a lorry driver. The man was remanded into custody by a Magistrates' Court on 5 September 2009 after being charged with supplying drugs. He arrived at HMP Birmingham the same day. This was not his first time in prison. The man transferred to HMP Hewell five months later on 29 January 2010.

32. At his first reception health screen interviews, it was recorded that the man was awaiting surgery for a hernia and that he had previously had surgery for a perforated stomach ulcer in 2001. The following medication was prescribed for the man whilst he was in custody at Hewell: omeprazole (for his stomach problems), zopiclone (to help him sleep), venlafaxine and sertraline (for depression) and quetiapine (an anti-psychotic medication). He was a smoker but chose not to accept help to stop smoking.

33. Around 8.45am on 18 March, the man jumped from the second floor landing (the 3s landing) on A spur in Houseblock 1. He had tied a ligature around his neck and attached this to the bars on the landing. His fall was broken by a bin which had recently been placed directly under where he fell. An officer responded immediately and cut the ligature. She was assisted by a prisoner who supported the man's weight whilst the ligature was cut.

34. An ambulance was called and the man was taken to outside hospital. He was found to have fractured his hyoid bone (a bone in the neck, between the chin and the thyroid gland) but, as this was not thought to be life threatening he was later transferred to another hospital. The man returned to Hewell the same day and was placed on constant supervision in a gated cell with an officer outside.

35. A Senior Officer (SO) from the Safer Custody Team received a telephone call from the man's partner at around 9.40am on 18 March. He made the following note about the call:

> "Concerned, she had an argument with the man, he admitted to having an affair, and had been told she was seeing someone else, she denied that but did state she was finishing with him due to the affair. They have been together 22 years and have three grown up children between them from previous partners. The man has two she has one. She stated they have five grand children between them."

36. As the man was at risk of harming himself, the Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support arrangements were started.

37. When interviewed as part of this investigation, a Senior Mental Health Practitioner at Hewell confirmed that she was contacted by hospital staff during the evening of 18 March and was asked to carry out a mental health review when the man returned to Hewell. She confirmed that the review took place during the evening of 18 March and said:

> "He was very distressed, he was very tearful, he was very emotional. He had difficulty in composing sentences because he was unable to speak because he was so emotional. He stated he wished he was dead, he wished he had succeeded. He was adamant that it was a suicide attempt and he was upset that he had not succeeded."

38. In her interview, the Senior Mental Health Practitioner described the man's demeanour at the review:

> "The man engaged well. At that point he seemed more reflective … He described how he had been planning the suicide attempt and it was about maybe a week, three or four days, a week, of actually planning what he was going to do. He described having a dry run and having a ligature that his pad mate had found and had thrown it out the window because he hadn't realised the significance of what it was. For me, from talking to the man then, there was a lot, it was quite an in depth attempt, it wasn't an impulsive attempt, it had been well planned, well thought out and the intention did seem to be to take his own life."

39. When asked about what had caused the man's state of distress, she said:

> "He was concerned about being back in custody. He had been moved from two previous establishments. He didn't mention any issue with these moves but he had had changes around. He had stated that he had got loosely involved with gangs while in another jail and was on the fringes of that. I think [he] had been holding a mobile phone or something for them, and had got found with it. Obviously he was having to carry the can because he had lost their mobile phone so that was more his issue with being moved rather than anything to do with the other establishments. He was looking at possibly the longest sentence he had ever done. He was worried about his partner … and whether their relationship would survive. He said that she hadn't given any indication that it wouldn't, there hadn't been a letter, there hadn't been any bad phone calls, anything like that, but he just felt that the relationship wouldn't be able to stand this."

40. The SO for the Safer Custody Team and the Senior Mental Health Practitioner saw the man at the ACCT case review during the morning of 19 March. The following was recorded in the ACCT record:

> "The man remains very low in mood and distressed, he maintains he will kill himself if he gets the chance. Issues around medication and contact with family … We agree to remain on constant supervision to

> be move[d] to lower medical [ground floor of the healthcare centre] ASAP – and engage when possible, still very high risk of completing suicide – requires experience and robust supervision."

41. Following his ACCT review on 24 March, the man's risk of self-harm was reduced, from "high" to "raised". He moved from the healthcare centre to C spur on Houseblock 4 to a shared cell (C3/34). The man was also employed as a cleaner on the spur.

42. The ACCT procedures were closed on 5 May, when the medical assessment identified that the risk of self-harm had abated and that the man had come to terms with his situation. The following entry was made in the record of the case review:

> "The man feels he has progressed greatly since first placed on ACCT. He engages well throughout. Eye contact was good and conversation was spontaneous. Firmly denied any thoughts of self-harm or suicidal ideation at this time. Still under review by psychiatrist and Senior Mental Health Practitioner. This will continue. All in agreement, document to close."

43. A week later, on 12 May, an ACCT post closure review was conducted by a SO who was based on Houseblock 4. The Houseblock 4 SO wrote in the man's record: "States he feels embarrassed reference his suicide attempt, but feels supported by staff on the unit and his family outside [and] receives regular visits."

44. The man attended a consultation with the prison's psychiatrist on 3 June. The following was recorded in his medical record:

> "Expressed his worries that his girlfriend has not visited him for two weeks, feels that their relationship might not continue and that she might move on with her life … Expressed his anxieties that although his family have been supporting him, but now they are busy with their lives and his is getting sidelined and that they would not listen to him as they are doing now … Currently no thoughts or plans of self-harm or suicide or violence but has a history of impulsive behaviour and actions from past, hence risk of self-harm or suicide stays depending on the relationship with partner, family and sentencing."

45. On 9 June, the man was taken to outside hospital for a hernia operation. Whilst he was in hospital, the initial security risk assessment identified that an escort chain (a set of handcuffs linked by a chain) should be used and two prison officers should accompany him. The man returned to Hewell later that same day but chose not to be admitted to the healthcare centre. A log of activities was maintained by the officers on bedwatch duty. This would have been checked on a regular basis by a visiting duty governor if the man had remained in hospital

46. Following concerns raised by officers and staff from the chaplaincy, the ACCT procedures were put in place again on 21 June. In the ACCT document, the Houseblock 4 SO described the man as quite depressed about his relationship with his partner. He was again placed on constant watch and moved to a cell in the healthcare centre.

47. During the morning of 23 June, the man attended his first ACCT review. The following entry was recorded in the record of the case review:

> "The man is very emotional at present and feels that everyone is trying to do things that are not in his interest. The man is telling the team that he is okay and just wants to be off the constant supervision. The team feel that there are still underlying issues and that the man is holding something back. The team have agreed that the man have his medication reviewed today and the man will be reviewed again Thursday for supervision."

48. The next ACCT review was held on the following day, 24 June. The following was recorded as a summary of the review:

> "The man appeared very resistant to comments that were made by all. Employment and engaging in activity during the day and returning to Lower Medical. The man has had several outbursts yesterday and the staff felt that these were due to the man not getting the response he wants. The man is to [be] monitored by a management plan and during this time he will remain in Lower Medical. The man will be reviewed on Friday."

49. During the afternoon of the following day, 25 June, a further ACCT review took place. The following entry was made in the record of the case review:

> "The man appeared very anxious and shaky, he has stated he is still having problems sleeping but is getting approx 6 hours sleep. The man concerns are still about … his relationship with [his partner]. His visit on Monday will hopefully put things into place and will be an opportunity for all parties to have their say. The man states he has no suicidal thoughts at present but the team feel that as a precaution and his unpredictability he remains on constant supervision."

50. During the morning of 28 June, a special visit was arranged to enable the man to meet his partner and children in a supportive environment. The visit was held in the chapel and another SO from the Safer Custody Team attended.

51. When interviewed as part of this investigation, the SO from the Safer Custody Team described how the man's daughter had told him at the visit to give his partner some space. The SO said that the man's daughter advised her father to stop telephoning his partner. The SO said that his daughter also told the man that his partner wanted a break and he needed to move forward with his life.

52. The SO confirmed that the man's partner asked for all of her telephone numbers to be removed so that he could not contact her. The man's partner said that this was because she could not cope with what she described as the constant harassment from the man. (However, the man's partner allowed her home telephone number to be reinstated shortly afterwards.)

53. Later in the day, the man went to an ACCT review and the following entry was recorded:

> "The man was upbeat in the review and appears to have taken this morning's visit well. The man states he intends to continue taking his medication and engage with staff for support during this difficult time. He is happy to be locating in the medical within a normal cell and television. The man has agreed to adhere to the regime and hopes he will be able to focus in getting himself better. He will be reviewed again on Wednesday [30 June]."

54. Two days later, on 30 June, the man attended an ACCT review. It was recorded that he seemed to be in a positive mood and that he was aware of the need to engage with staff to help his move to back to the houseblock. The following was recorded: "The man states he has no intentions of self-harm or thoughts of suicide."

55. Following the review the man's risk of self-harm was reduced, from "high" to "raised". He was seen by a member of the Independent Monitoring Board (IMB) who visited the healthcare centre whilst making his rounds of the prison. In an e-mail to the Chair of the IMB, the member wrote:

> "The man is still in Lower Medical but no longer in a gated cell on constant watch. I spoke to the officer in charge who told me that he is now on "12 in 60" i.e. checked every five minutes. I checked his ACCT, signed and dated it. He is in a normal cell now and I had a quick in [went into the cell]. All okay."

56. On 1 July, the man went to the next ACCT review meeting. The following entry was recorded:

> "The man has seen the psychiatrist who has stated he is happy for the man to go back to normal location. The man is happy with the plan in place states he will adhere to the regime. The man states [he] has no thoughts of self-harm or suicide, the issues with his partner are under control and states the break he can cope with. His family are being very supportive. The man has good conversations and eye contact. Obs [observations] reduced."

57. After his attendance at the ACCT review meeting and meeting with the prison psychiatrist, the man returned to C spur in Houseblock 4 to his shared cell. Support and monitoring was continued under the ACCT process, with the level of staff observations reduced to at least three conversations during the day (one each during the morning, afternoon and evening, all of which were to be

documented). Additionally, the man was to be observed twice every hour which was also to be documented. He also continued with his duties as a wing cleaner.

58. On 6 July, the man told an officer that he felt stressed as his partner had ended their relationship. The following entry was made in the ACCT record: "He said he is not going to do anything to himself but he feels strange and has got the shakes." Two days later, on 8 July, the man appeared to be in a good frame of mind and the following entry was made by the same officer: "The man has mixed on the landing during association, he has been on the phone, he appears in good spirits."

59. In his statement to the police, the man's cell mate confirmed that he had known the man for approximately three months. He said: "… on a weekly basis the man mentioned to me that he had suicidal thoughts but he always told me that they were only thoughts and he never intended on acting upon them".

60. The cell mate confirmed that in the two weeks leading up to his death the man was quite depressed as his partner had told him that she wanted some space and was not intending to get back together with him. The cell mate said:

> "… the main reason for this was the constant abusive telephone calls that she was receiving from the man. Following this the man spoke with the Listeners and told them that due to the situation with his partner he was seriously considering suicide. From this the man was moved to the prison hospital and he remained in there for ten days."

61. According to the cell mate, when the man returned from the healthcare centre, on 1 July, he appeared fine and remained that way until 7 July. The cell mate said:

> "I helped the man write a letter to his partner which the man wanted to do to help patch things up between them both. After helping the man write this letter, his mood changed and he started mentioning suicide. The man continued this throughout the Wednesday (7 July) and then into Thursday 8 July."

62. In his statement, the cell mate confirmed that the man did not tell him how or when he intended to commit suicide but he did say to him: "I know how I'm going to it."

63. When interviewed as part of this investigation, the cell mate again drew attention to the man's relationship with his partner. The cell mate said:

> "He kept on making ultimatums to his missus on the phone because they were having a rocky relationship over the period of about ten months. He was quite abusive to her over the phone [because of] his own paranoia and she broke up with him. So he was basically saying … if she didn't get back with him that he definitely do himself in and all that sort of stuff … I can say that he was relieved when he was back on

the wing. He was determined to end it. But I knew that one day it was definitely going happen."

64. During the afternoon of 8 July, the man attended what was to be his last ACCT review meeting. The review was managed by an SO from the Safer Custody Team and an officer from Houseblock 4 was also there. The following entry was recorded in the record of the case review:

> "States he won't be taking his prescribed anti-depressants in the morning, but is happy with evening meds [medication]. States he is occupying his time cleaning, associating and going to gym, he seemed much more articulate today and was not tearful and confused as he has been in the past."

65. Following the ACCT review, the frequency of conversations continued to be three during the morning, afternoon and evening, which were all to be documented. However, the man was now only to be checked once an hour which was to be documented every three hours. His risk of self-harm was assessed as having reduced to low. From the records seen by my investigator and the clinical reviewer, there was no evidence that any healthcare staff attended the review. It also appears that a medical or psychiatric opinion was not sought before the reduction to the frequency of ACCT observations and the level of risk.

66. In her statement to the Governor dated 12 August, a CARAT worker confirmed that she saw the man on a couple of occasions on the day before his death. The CARAT worker did not record her conversations with the man on his ACCT documentation. In her statement, she wrote:

> "The man was employed as the sterile area cleaner on Houseblock 4 and as the CARAT office is also based on Houseblock 4 we spoke most days that I was in at work. On some days he could be very upbeat and positive and on some days he could be low and despondent and he would like to chat. Likewise he would notice if I was a bit distracted. On Thursday 8 July 2010 I saw the man cleaning on the sterile area of Houseblock 4. It occurred to me that I had not seen him for a couple of days and I said it was good to see him back as he did a good job cleaning the Houseblock. He said he had had a lapse for a few days. I assumed he meant a drug use lapse and I asked if he wanted to talk about it. He said "no up here" and he pointed to his temple. I asked him if he was alright and he said he had been on remand for 13 months and it was getting too much from him. He also said that he had fallen out with his wife again. I asked if he would be alright and he said he would and he did not mention self harm. Later that day I saw him again on Houseblock 4 and he was emptying the rubbish from the bins … He seemed quiet and I again asked if he was alright and he nodded his head and said yes. He did not mention self harm."

67. My investigator has been unable to interview the CARAT worker about her dealings with the man, as she is currently not at work for reasons unrelated to the man's death. I shared her statement with the Head of Safer Custody at Hewell. In response, he wrote:

> "Any member of staff that deals with a prisoner who is on ACCT should record their observation in this document, this would then enable all readers to be aware of any issues that are alive and active."

Friday 9 July

68. At about 9.00am on 9 July, the cell mate left their cell to go to education. The man seemed happy when he left and had told him that he was going to make a few telephone calls to friends.

69. In his statement to the police, an officer from Houseblock 4 said during the morning of 9 July the man appeared "cheerful". He confirmed that they had a conversation about his recent hernia operation and that he had seen him using the telephone on the spur. After receipt of the draft report, the solicitors representing the man's queried the accuracy of the recording of the interactions between staff and the man on 9 July. I cannot comment further on this point as no further information has come to light other than what has already been presented in this report.

70. Later at about 9.40am, the Duty Governor began her rounds of the prison. She visited Houseblock 2 and, about 20 minutes later, had just arrived on Houseblock 1 when she was contacted by the control room via her radio. The Duty Governor was asked to go to the nearest telephone extension so that she could receive an external call. The switchboard operator informed the governor that a woman was on the telephone who wanted to talk to someone about threats from her partner. When the Duty Governor took the call, the man's partner told her that he had been threatening and harassing her over the telephone.

71. In her statement to the Governor written on 12 July, the Duty Governor wrote:

> "I asked her [The man's partner] for some more detail as to the nature of the threats and she said she had spoken to him this morning and that he told her he was sending people round right then to sort her our there and then. At this point I recall thinking she sounded fearful and upset. I asked her if she had anyone with her and she said that she had locked herself in the house and would be contacting a friend to come and sit with her … Throughout the call she expressed fear of what might happen to her and appeared angry that these threats were being made and wanted to stop all contact. At no point did she say she was concerned for the man's safety other than the statement that she made when she was giving me a factual description of the content of their telephone calls over the previous several days, which I had requested from her."

72. When my investigator and the Ombudsman's family liaison officer met the man's partner, she was adamant that she also mentioned to the Duty Governor about the risk that he might harm himself.

73. After the call ended, the Duty Governor carried out background checks on the man and spoke to a SO from the Safer Custody Team about her conversation with the man's partner. They agreed to meet later in the Security Department where they could check the records of the telephone calls made by the man.

74. At around 10.30am, the Duty Governor was contacted by a SO who is based on Houseblock 4. The SO wanted to discuss a prisoner who was refusing to comply with instructions and she advised to place him on report. The governor also informed the SO about the threatening telephone calls to the man's partner. The Duty Governor asked if someone could check on the man as he had previously threatened to harm himself.

75. The man's cell mate returned to the wing around 10.40am and was escorted back to his cell by an officer. When they arrived at the cell the door was locked. The officer unlocked the door and they went into the cell.

76. In her statement to the Governor, another officer confirmed that she was on the first floor landing (known as the 2's landing) when the cell mate returned to C spur on Houseblock 4. The officer's statement notes that the cell mate went on to the 3's landing and approached his cell at the same time as another officer who was there to close the cell. The officer on the first floor assumed that the cell mate could not get inside as the privacy lock was on. As the man worked as a cleaner, he was not locked inside his cell by staff. .

77. The officer confirmed in her statement that it would have been necessary for her colleague to have opened the cell door for the cell mate as there was only one key to the cell, which was held by the man. As the man was employed as a cleaner, he used to keep the key so that he could secure his cell whilst he was carrying out his domestic duties. The officer explained that for a member of staff to take the privacy lock off a cell door (when the main cell door handle is at 45 degrees) it is necessary to put the full lock on (main cell door handle is horizontal). The lock is opened again which pulls back both the main lock and the privacy lock in order to gain entry. In a meeting with my investigator, the officer confirmed that she had not locked the man's cell door during the morning of 9 July and she thought that the man must have put the privacy lock on.

78. The investigator interviewed the man's cell mate and two other prisoners who had lived on Houseblock 4. In his interview, the cell mate was adamant that when he arrived back at this cell on 9 July the door was locked from the outside. He suggested that my investigator speak to two other prisoners as the cell mate thought that one of them may have seen which officer had closed the cell door. At interview the two other prisoners both confirmed that they had not seen an officer lock the man's cell door.

79. When the cell mate and the officer entered the cell they could not see the man. In his police statement, the cell mate said that as he looked towards the toilet door, he could see trainers at the bottom of the door. The cell mate called the man's name a couple of times but did not get a response. The officer then opened the toilet door and found the man hanging from a ligature. He had made a ligature from a bed sheet and tied it around his neck and attached to the toilet door. As the toilet door opened the man fell forward and the officer lowered him to the floor. The officer then used his radio and asked for assistance. He called for a code blue response (a radio code which is used to indicate an emergency where someone was not breathing). The officer then commenced cardio pulmonary resuscitation (CPR). At this point, the cell mate was asked to leave and he was put in a cell with another prisoner.

80. The officer was joined soon afterwards by two SOs, the nurse designated to respond to emergencies and another nurse. CPR continued and the man was also connected to a defibrillator, which indicated that there was no electrical activity in his heart. However, there was some confusion about whether the defibrillator was working properly. Whilst the man was being attended to the other prisoners were locked in their cells. A prison doctor arrived at the cell around 10.49am. They were joined by paramedics nine minutes later, at 10.58am, who took over the man's care. The ambulance left Hewell at around 11.40am and the man was taken to a local hospital. He was accompanied by two officers in the ambulance but restraints were not used. The man was pronounced dead by a hospital doctor at 11.56am.

81. Prisoners were informed of the man's death after they were unlocked from their cells. They were also asked whether they required any support or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) All the prisoners on the ACCT self-harm observation and support regime were reviewed. An ACCT form was opened for the cell mate as he was quite upset by the man's death.

82. After the man died, the prison activated its death in custody contingency plan. The police visited Hewell and interviewed staff and the cell mate. They found no suspicious circumstances.

83. After the death of a prisoner, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and staff support. The Head of Operations at Hewell held a hot debrief in the early afternoon of 9 July. It is not clear who attended as healthcare staff were not invited and no record was taken of the meeting. The Head of Operations spoke to the healthcare staff separately after he finished the meeting. No areas of concern were raised at that time but the staff who tried to resuscitate the man were offered support from the prison's care team. As minutes were not taken this meant that there was no record of what was discussed and whether there was any learning from the events surrounding the man's death.

84. After the man passed away, staff from Hewell went to the home of the man's partner to inform her about his death. Unfortunately, she was not at home and her mobile telephone was switched off. They also visited her place of work and found that she was not there. The man's partner then contacted the prison and was informed of his death. The prison appointed a family liaison officer who maintained contact with the family and assisted with the funeral arrangements. Hewell also offered financial assistance with the costs of the man's funeral. The man's funeral took place on 29 July.

ISSUES CONSIDERED

85. As mentioned earlier in the report, the man's partner met with the investigator and the Ombudsman's family liaison officer. The Ombudsman's family liaison officer also spoke to the man's daughter to gather her concerns.

86. The man's partner and his family wondered why, following her telephone conversation with Duty Governor, immediate action was not taken to check on the man's well being. In her statement to the Governor and at interview, the Duty Governor was adamant that at no time during her conversation with the man's partner was mention made of the risk of him harming himself. The Duty Governor states that the focus of her conversation with the man's partner was the threat of physical violence against her.

87. The telephone calls made by the man during the morning of 9 July were recorded. According to the transcripts, the man was clearly very upset about the breakdown of his relationship with his partner. Although the initial conversations were cordial, the tone rapidly deteriorated and there were a number of very abusive telephone calls. I will not dwell on what was said by the man during his calls as a copy is annexed to my report. One point which was clear was that the man threatened violence against his partner.

88. I cannot comment on the content of the conversation between the Duty Governor and the man's partner as this was not recorded, and there are differing accounts about what was said. However, the action taken by the Duty Governor after the call ended suggests that she was indeed taking action to check what the man said in his telephone conversations with his partner that morning. The subsequent conversations between the Duty Governor and the SOs from the Safer Custody Team and from Houseblock 4 all seem focused on finding out what the man had been saying in his telephone conversations. Both SOs were very clear about their interpretation of what had been discussed between the Duty Governor and the man's partner. They were also both adamant that self-harm was not mentioned which would have led to immediate action to check on the man's well being, especially as the ACCT procedures were in place at the time. After receipt of the draft report, the solicitors representing the man's family were still concerned about the actions taken by the Duty Governor and why she did not immediately act to check on his well being. I am sorry that I cannot add anything further on this point as I have no additional information to act upon.

89. The man's family and partner also wondered why his cell door had been locked whilst he was in the cell by himself and subject to the ACCT monitoring procedures. They had been informed by the cell mate that when he returned to the cell the door had been locked from the outside and had to unlocked by the officer. When interviewed as part of the investigation, the officer stated that the cell had been closed using the internal privacy lock, which he was able to override with his keys.

90. In a statement to the Governor, another officer who was working on Houseblock 4 on C spur, states that she did not lock the cell door. In her statement, the officer also said:

> "I went onto the 2's landing and Officer A went on to the 3's landing, and we commenced locking down at the same time, as we were locking up, some prisoners had returned to the houseblock from work and were let onto the spur, one of these prisoners was the cell mate, I instructed that all the prisoners that were returning from work and the domestics should return to their cells for lock up as there was a full staff briefing that morning, which they did. The cell mate went onto the 3's landing and approached his cell at the same time as Officer A. Officer A then opened the cell for the cell mate. Officer A had only just got to that particular cell to lock down so I can only presume the privacy lock was on as the man was a domestic and was never locked behind his door during the working day so that he could complete his duties. Officer A opened the cell to let the cell mate in, it was then that I heard a commotion. I then responded to the 3's landing and asked the cell mate to come down on to the 2's landing where I locked him in another cell with another prisoner. I then returned to the 3's landing and continued to lock down as the SO and Officer A were tending to the man."

91. For a member of staff to take the privacy lock off a cell door, it is necessary to put the full lock on and then open it again which pulls back both the main lock and the privacy lock in order to gain entry. As mentioned previously, my investigator interviewed two other prisoners who had been housed on Houseblock 4 at the suggestion of the cell mate. Neither prisoner saw an officer lock the man's cell door. My investigator was therefore unable to clarify whether the door had been locked by a member of staff or the privacy lock applied by the man himself. In their response to the draft report, the solicitors representing the man's family noted that the issue had not been resolved concerning whether the cell was locked from the inside or outside. As mentioned previously, I cannot comment further as not additional evidence had come to light.

92. The man's family and partner confirmed that some belongings had been returned to them following his death, but that some items were missing. After the man's attempted self-harm on 18 March, he informed his partner that he had written to her. The letter was not amongst the belongings she received. The man's daughter did not receive a card that his granddaughter had sent to him, and which she knew he received.

93. My investigator discussed the concern about property with the prison's family liaison officer. In her liaison log, she wrote that it had been agreed that she return the man's belongings to his daughter. The man's partner later informed the prison's family liaison officer that his daughter had arranged for someone "to bring over what was left of the property to her". The prison's family liaison officer confirmed that, after she had been informed about the missing items, she had checked with the Security Department at Hewell and staff on

Houseblock 4 but was unable to trace any more property. She also contacted the police to check if they had retained any of the man's belongings. It was discovered that a ring and clothing was in a police property store and this information was relayed to the family by the prison's family liaison officer.

94. My investigator tried to find a resolution to these concerns. The property noted in the man's records has been returned but the family do not accept that this was all of his belongings. Unfortunately, I do not know how to resolve this situation with regard to the alleged missing property. I regret that my investigator was unable to resolve this issue satisfactorily.

Clinical care

95. As noted, a review of the man's medical care was undertaken by a doctor on behalf of Worcestershire Primary Care Trust.

96. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. In her review, the clinical reviewer draws attention to the fact that the man was not known to have mental health problems before he arrived at Hewell and had no significant history of drug or alcohol abuse. His existing hospital appointments were honoured and, in the clinical reviewer's opinion, the man's post operative care after his hernia surgery was of a high standard.

97. The clinical reviewer notes that the man was fully assessed and monitored by the mental heath team and by psychiatrists after his first suicide attempt. In relation to his first suicide attempt, the clinical reviewer wrote:

> "His first suicide attempt was wholly unexpected and appears to have been a spontaneous and determined act. It was never clear whether The man believed he would die when he jumped from the railings or whether he chose this time, place and method knowing that staff would be on hand quickly to save him."

98. In the clinical reviewer's opinion, the man "was given a huge amount of time and support by both the mental health team and by prison staff". She found that the man's medication was tailored to his symptoms and to his self-reported changes in his symptoms. The clinical reviewer states that it would be difficult to see how the man could reasonably have had more intervention from the mental health and safer custody teams. When he was seen by the prison psychiatrist on 1 July it was decided to continue the current medication and review him two weeks later. The clinical reviewer wrote:

> "Clearly at this time the man presented himself as stable, well, and with a good degree of self-control. He gave no indication that he was planning suicide, nor that a spontaneous act was a possibility."

99. In her review, the clinical reviewer states that she finds no reason or cause to criticize the level of care that the man received from either the healthcare or prison staff.

100. However, the clinical reviewer draws attention to the problems encountered with the defibrillator. In her opinion, as the defibrillator did not recommend that a shock should be administered, cardio pulmonary resuscitation (CPR) gave the man the best chance of survival. The clinical reviewer wrote: "It is very rare for people to survive cardiac arrests outside of hospital. Those who do and where a defibrillator is used almost always have a shockable rhythm." However, given the problems that staff encountered when they tried to use the defibrillator, the clinical reviewer recommends that defibrillators should be regularly checked and all staff should know how to use them.

The Governor and Head of Healthcare should ensure that defibrillators are regularly checked, staff know where they are located and also know how to use them.

101. The clinical reviewer wrote that it was "admirable that prison staff were well trained in CPR and felt confident to undertake an attempted resuscitation and to perform CPR to a high clinical standard". She suggests extending CPR training to more non-medical staff at Hewell and the Governor and Head of Healthcare will wish to consider the suggestion carefully.

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102. Both the clinical reviewer and my investigator encountered problems finding information in the man's records. It is important that staff are aware that they should record names, dates and accurate or approximate times on all information in the medical record, even when it is recorded at a later date.

The Head of Healthcare should ensure that all medical staff are trained and kept updated in record keeping. An audit plan should be put in place particularly concerning standards of documentation.

Use of Assessment, Care in Custody and Teamwork procedures

103. The Safer Custody Team at Hewell manages all Assessment, Care in Custody and Teamwork (ACCT) cases. Members of the team attend all the reviews with prisoners and when ACCTs are closed, they closely monitor the prisoner to ensure that they continue to be actively supported. I am satisfied that the man was being monitored correctly by staff after his attempt of serious harm on 18 March. When it appeared that the risk of harm had diminished the ACCT was closed appropriately on 5 May. Staff continued to support the man after the ACCT closure to ensure that he did not have any more concerns and, when the risk of harm increased, the ACCT was opened again on 21 June.

104. The man showed a positive attitude to staff during the days leading up to his death. He engaged with staff and accordingly the observations were reduced from constant supervision to two observations per hour. The level of observations was reduced further to once per hour the day before the man took his life. Other than the words to his partner, I have not found any indications that the man intended to harm himself and staff were shocked when they discovered him hanging in his cell. As mentioned in interviews with staff, the man's mood could change quite quickly. Although the catalyst for his final act

of self-harm is not clear, I believe that staff had acted in his best interests throughout his time in custody. It is unfortunate that the switchboard staff and the Duty Governor did not recognise the concerns which the man's partner said that she expressed. Nevertheless, I believe that the governor was already responding to the threats on the partner, even as the man took his life.

105. The man appears to have developed relationships of trust with several members of prison and healthcare staff. He was open about his fears, concerns and personal relationship difficulties. At interview, prison staff spoke perceptively and empathetically about their relationship with the man. This speaks well of the care offered to him during his time in custody and is a credit to the staff at Hewell. The Governor may wish to share that assessment with both managers and staff.

106. However, as mentioned earlier, a member of the CARAT team did not record her interactions with the man on his ACCT document the day before his death. Her statement suggests that his mood may not have been as positive as was thought by other staff. My investigator suggested to both the Governor and his Head of Safer Custody that it would be advisable to discuss this issue with the CARAT team and consider the training needs for the member of staff concerned. The solicitors representing the man's family drew attention to the interaction between the member of the CARAT team and the man on the day before his death. They felt that an increase in his observation levels and level of risk should have been considered. It was unfortunate that the negative interaction between the CARAT worker and the man did not come to light until after his death. I cannot add any further information on this subject other than staff at Hewell responded to the information being presented to them by the man.

CONCLUSION

107. The man arrived at HMP Hewell on 29 January 2010 after transferring from HMP Birmingham. On 18 March, he made a serious attempt to harm himself by tying a ligature to the bars of the landing and jumping off. The ACCT self-harm monitoring procedures were put in place until, when the risk of harm had appeared to have reduced, they were closed on 5 May. However, they were re-opened again seven weeks later on 22 June when the risk of self-harm increased. I am satisfied that the ACCT procedures were used properly and I make no criticism of the decision to reduce the level of monitoring on 8 July. The man appeared to be more cheerful and was using his time constructively. Nevertheless, on the next day 9 July, The man was found by staff hanging in his cell. He was taken to outside hospital where he died shortly after his arrival. His partner said that she reported her fears that he would harm himself but prison staff only heard her anxieties about the threats to herself.

108. In her review, the clinical reviewer said that she could not see any way that the man's death could have been anticipated nor action taken to avoid it. I concur with the clinical reviewer's view that the man appears to have received a high standard of care whilst he was at Hewell. The clinical reviewer also judges from the records that the reductions in ACCT observations was appropriate. The man appeared to be coping well with his relationship problems and the frustration of waiting for a court date. As the clinical reviewer says, "maintaining a high level of [ACCT] observations can be counter-productive for some people as it takes away any semblance of normality". Regrettably, the man used the opportunity to tie a ligature round his neck.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations made. That response is included in italics below each recommendation.

1. The Governor and Head of Healthcare should ensure that defibrillators are regularly checked, staff know where they are located and also know how to use them.

   Recommendation accepted - Defibrillators are part of a contract and these are checked annually. All nursing staff are qualified in Immediate life Support (ILS) and are aware of the location of all Defibrillators.

2. The Head of Healthcare should ensure that all medical staff are trained and kept updated in record keeping. An audit plan should be put in place particularly concerning standards of documentation.

   Recommendation accepted - A new computerised patient record Systm1 has now been introduced. Training on record keeping is available for all staff. And all new staff receive this training on induction.