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

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the death of a prisoner at HMP Hewell who died on 12 September 2010. On 7 September, after concerns were raised about the man's wellbeing, he was placed on the prison's self-harm monitoring and support procedures. The procedures were still in place on 12 September, when he was found hanging in his cell. The man was taken to a local hospital where he was pronounced dead. He was 47 years old.

I would like to offer my sincere condolences to the man's family and to all those affected by his death.

The investigation was undertaken by one of my investigators. 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 his report. The reviewer concludes that the man's clinical care was comparable to what he would have received in the community. I endorse the recommendations which concern the failure to discuss the man's care at the healthcare multi-disciplinary meeting, and reviewing the action to take when prisoners do not attend medical appointments.

I am generally satisfied that the self-harm monitoring and support procedures were used properly. However, the discussions about the risk that the man might harm himself would have benefited from a contribution by healthcare especially as he was prescribed a medication which increases the risk. The man was left alone in his cell after he harmed himself, I think that staff made a careful decision about whether this was safe. Regrettably, this was not to be and, two days later, the man took his life.

All of the recommendations made in the draft report have been accepted by Hewell. I have included the prison's response to the recommendations at the end of this report.

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

Thea Walton
Deputy Prisons and Probation Ombudsman **November 2011**

CONTENTS

SUMMARY

1. The man was born in 1962. He was 47 years old when he died on 12 September 2010 at a local hospital. The man had been found hanging 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 July 2010 and he arrived at HMP Hewell on the same day. During his first reception health screening interviews, it was recorded that he had history of alcohol dependency and problems with his spine.

3. On 7 September, concerns were raised by staff about the man's wellbeing. He appeared confused, was not eating properly and had lost a lot of weight. Accordingly, a self-harm observation and support regime was started. This involved regular checks being carried out and recorded.

4. During the morning of 9 September, the man informed staff that he had harmed himself. He had slight lacerations to his wrist which were treated by healthcare staff. The man returned to his cell on the same day and the observations were increased to twice hourly. On the following day, 10 September, the man's cellmate left the prison to go to court and was subsequently released from custody. Prison staff were not informed of his release. Consideration was given to moving someone else into the man's cell but staff decided not to do so because of the man's vulnerability and in case his cellmate returned.

5. During the morning of 12 September, staff discovered the man hanging from a ligature attached to the back of his toilet door. The man was laid down on the floor of his cell and staff asked for 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 escorted by two officers. Despite the extensive efforts to resuscitate the man both at the prison and hospital, he was pronounced dead by a hospital doctor at 9.32am.

6. The clinical review carried out 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. I endorse the clinical reviewer's two recommendations concerning the failure to discuss the man's care at the healthcare multi-disciplinary meeting, and reviewing the action to take when prisoners do not attend medical appointments. I understand that the prison health partnership is considering the findings from the review and developing an action plan to address them. I also recommend that healthcare staff attend case reviews especially when a prisoner should be receiving healthcare treatment.

THE INVESTIGATION PROCESS

7. My investigator was formally notified of the man's death on 14 September 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 relevant to my investigation to contact the investigator. No responses were received. The investigator also studied all the relevant prison records relating to the man which 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 the 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 his report which was received on 28 February 2011 and 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 my family liaison officers contacted the man's family. 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 family raised the following matters:

    - How the man had been whilst he was in custody, did he keep to himself or have any problems, including health problems.
    - They were aware that he had been on self-harm observation but wanted more information about this.
    - The man had lost a lot of weight before his death and the family want to know why this happened.

    I have attempted to address these issues within the report. I hope that this helps the man's family to understand the events leading up to his death. The man's family received a copy of my draft report and commented on it. They drew attention to the correspondence they forwarded to the man's General Practitioner (GP), the police and mental health services where they raised concerns about his mental health. Unfortunately, these concerns were not passed onto Hewell by these agencies when the man was received into custody.

11. The investigator visited HMP Hewell on 14 September and spoke to the Governor as well as other staff involved in the care of the man. He returned on 4 and 26 October and 15 November to interview staff. The investigator also carried out a telephone interview with a nurse and met the Chair of the Independent Monitoring Board.

12. 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

13. 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.

14. The prison accommodates Category B, C, and D prisoners. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt. Category D: open conditions, prisoners who can be trusted not to try and escape.

15. There are seven houseblocks, each divided into wings. Houseblocks 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 houseblock 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 which includes taking into account 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 the 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 (MDT) meeting is held to discuss each individual prisoner, regardless of whether they are physically or 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.

[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

19. Hewell recruits experienced prisoners to operate as Insiders and Listeners. Insiders are experienced prisoners who welcome new prisoners, highlight any concerns and explain the processes they will encounter in the early days of custody.

20. Listeners support prisoners who may be at risk of suicide or self-harm. They are selected, trained and supported by the Samaritans to offer confidential emotional support 24 hours a day, to fellow prisoners in distress. The Listeners scheme is confidential and any prisoner can ask to speak to a Listener any time of the day or night.

Roll check

21. 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)

22. 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 support, 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[2] and other staff. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. The arrangements are reviewed regularly by a multi disciplinary meeting, which should include the prisoner.

23. ACCT support procedures are pivotal in the management of any prisoner thought to be at risk of suicide or self-harm. The ACCT plan is the principal tool for assessing, monitoring and managing any prisoner through a period of crisis. ACCT procedures can be initiated by any member of staff, irrespective of grade or discipline. The ACCT plan itself contains instructions and guidance for its use.

24. If a member of staff has reason to believe that a prisoner is at risk of self-harm or suicide, he or she must open an ACCT plan immediately by completing a 'Concern and Keep Safe' form (this documents the main issues causing the prisoner to be at risk of self-harm or suicide). The following further actions must also be completed:

[2] Each prisoner is allocated a personal officer, who is the first point of contact for them.

- An immediate action plan must be compiled within one hour of the ACCT plan being opened. The purpose of the immediate action plan is to consider and record the most appropriate environment and regime required to support the at-risk prisoner prior to the first case review.

- An assessment interview must be conducted with the at-risk prisoner by a trained assessor within 24 hours of the ACCT plan being opened. The purpose of this interview is to examine in depth the reasons the prisoner is at risk. The details of the assessment then inform the initial case review.

- An initial case review must be conducted within 24 hours of the ACCT plan being opened. The review panel must, in conjunction with the at-risk prisoner, agree a care and management plan - or 'Caremap' - setting out goals or the prisoner to achieve, with the help of staff, in order to reduce his risk.

- Thereafter, regular multi-disciplinary case reviews must be convened, each involving the at-risk prisoner, so that his risk can be monitored and his caremap updated.

25. The ACCT plan can be closed once those involved in the prisoner's care, as well as the prisoner himself, are content that the risk has reduced to the point where formal monitoring is no longer necessary.

26. Once it has been agreed that ACCT support is no longer required, a post-closure interview must be held to ensure that problems have been resolved or reduced and that the level of risk has sufficiently dropped. The date for the interview is a matter for the case review team to decided, but it must be within seven days of the closure of the ACCT plan.

Independent Monitoring Board (IMB)

27. A prison's Independent Monitoring Board (IMB) is appointed by the Secretary of State for Justice from volunteer 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.

28. 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 the 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."

29. 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."

HM Chief Inspector of Prisons

30. The first inspection of the new HMP Hewell by the HM Chief Inspector of Prisons was in November 2009. In her introduction to the report of the inspection, the then Chief Inspector, Dame Anne Owers 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."

31. In regards to the support of prisoners who are subject to ACCT procedures, the Chief Inspector 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

32. 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

33. The man was born in 1962 in Birmingham. He was unemployed before coming into custody. The man was remanded into custody by a Magistrates' Court on 23 July 2010 after being charged with assault. He arrived at HMP Hewell on the same day. This was the man's first experience of prison.

34. At his first reception healthscreen interviews, it was recorded that the man was alcohol dependent, had been diagnosed with corrosion of his spine and had extensive bruising from a fight relating to his offence. (Initial healthscreen interviews highlight any immediate mental or physical health problems requiring referral to the doctor or other specialist service.)

35. Limited information was available regarding the man's social and health circumstances prior to his arrival in custody. During his healthscreen interview, the man confirmed that he been prescribed diazepam to help him sleep. He also told staff that he had not received mental health support prior to his arrival in prison and that he had previously self-harmed. It was not clear from the records when or how he had self-harmed. The man was seen by a prison doctor and a review appointment was booked for the following day, 24 July. It was also recorded that, if he appeared to be suffering from dehydration, he should be taken to hospital.

36. The following medication was prescribed for the man whilst he was in custody at Hewell: thiamine (vitamin B), diazepam (for anxiety, insomnia), lansoprazole (for stomach problems) and sertraline (an anti-depressant).

37. During the afternoon of 23 July, the man was taken to the Medical Assessment Unit of the local hospital as he had pain in his knees. It is not clear whether dehydration was also a factor in his referral but, if it was, healthcare staff had acted upon the instructions given earlier that day by the prison doctor. The man was prescribed Sando-K (a potassium supplement) and returned to Hewell the following day. He did not attend his review appointment with the prison doctor as he was in hospital.

38. Whilst the man was in the hospital, the initial risk assessment was that restraints (a pair of handcuffs linked by a chain) were to be used and two officers should remain on duty at his bedside (this is known as a bedwatch). A log of activities was maintained by the officers on bedwatch duty, which would have been checked on a regular basis by a visiting duty governor if the man had remained in hospital for any longer.

39. After his return from hospital, the man remained in the healthcare centre until 25 July for observation of his condition. He then moved to C spur on Houseblock 1. On the following day, 26 July, the man was seen by a member of the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team[3]. The following entry was recorded by the CARAT worker: "No physical

[3] 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.

or mental health issues at present but was hospitalised when he first came into Hewell."

40. Four days later, on 30 July, blood tests were carried out to check the man's potassium levels which were normal. There were no further entries made in the man's clinical record until he was seen by another prison doctor on 28 August.

41. An officer made the following entry in the man's record on 6 August: "Has plenty of ongoing health issues which does affect his ability to engage with a meaningful regime. No discipline or respect issues for staff."

42. On 28 August, a fellow prisoner accompanied the man to an appointment with the prison doctor. The doctor recorded that the man was slightly confused, experiencing hallucinations and hearing voices inside his head. The doctor also recorded that according to the man the hallucination and voices had only occurred since he had been in prison and not before his arrival in custody. The doctor made a referral to the Mental Health Team and also prescribed sertraline. It is not recorded whether the doctor discussed the side effects of the medication (there is rare increased suicidal thoughts after starting sertraline) with the man.

43. When interviewed over the telephone as part of this investigation, a Registered Mental Health Nurse confirmed that the first time she recalled meeting the man was on 3 September after she received a referral from the prison doctor. The nurse described the man as "quite bright mood wise and seemed to think that he would be leaving prison quite soon". She recalled that the man had issues with alcohol dependency.

44. As the nurse did not know about his offence, and as the man seemed confused about his legal status and she thought he may have been delusional, she asked a Probation Officer to come to see him. The man appeared to think that he had been in custody for over six months although he had only arrived at Hewell seven weeks prior (on 23 July) to his assessment with the nurse.

45. The nurse recalled that the Probation Officer explained to the man that he was on remand and not yet sentenced. The nurse was concerned that the man was confused and did not understand what had been explained to him.

46. The nurse did not think that the man presented as someone who was at risk of self-harm or suicide. She described him as having: "a good and positive mood although he seemed a bit confused so his mental health issues needed to be addressed". The nurse confirmed that the man came across as an unassuming individual, she had no concerns about his conduct and he was not threatening at all.

47. After the nurse finished her consultation, she placed the man on the psychiatrist waiting list for review. She recalled that the waiting list was quite short with only a handful of names on it. When asked about what she thought the next steps would be for the man's mental health care, the nurse said that

she assumed he would discussed at the healthcare multi-disciplinary (MDT) meeting[4] on the following Thursday (9 September) and reviewed quite quickly by a psychiatrist as the waiting list was not long. The nurse confirmed that she had no further dealings with the man after 3 September and she did not attend the MDT meeting on 9 September.

48. On 7 September, whilst she was on Houseblock 1, another Registered Mental Health Nurse was approached by an officer. He was concerned that the man had not been eating properly, looked withdrawn and was unsteady on his feet.

49. When interviewed as part of the investigation, the nurse said that was concerned about the man's physical health because allegedly he had not been eating an adequate diet. The nurse said that noted that the man was "a bit on the lean side". As the man appeared to be quite confused, disorientated and his mood was quite low, the nurse spoke to the officer and a Senior Officer on the houseblock about him.

50. The man was identified as at risk of harming himself and so an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support plan was started. A Senior Officer from the Safer Custody Team made the following entry in the assessment interview section of the ACCT form on 8 September:

> "He appears very fragile and was hard to communicate with. He states he is on medication for depression (sertraline) and has been on this for three weeks and he is feeling a lot calmer. The man states he doesn't sleep well he averages approx four-five hours a night. He has over the past two-three days increased his food intake … He has been referred to CPNs [Community Psychiatric Nurses] for a full mental health screen. He is due to see a doctor today for his physical health concerns."

The man did not attend his appointment with the doctor and it is not clear why this happened.

51. Around 11.15am on 9 September, the man informed staff that he had harmed himself. He had superficial cuts on both wrists, but it was not clear when the injury had occurred. He was taken to the healthcare centre where his cuts were treated and he then returned to the houseblock. The man had not harmed himself before whilst he had been at Hewell.

52. When interviewed as part of this investigation, an officer confirmed that the man was quite a withdrawn prisoner who mostly mixed with prisoners in his age group.

[4]A weekly multi-disciplinary meeting held to discuss individual prisoners (both of those who are physically and mentally ill).

53. A Staff Nurse made the following entry in the man's medical record:

> "States cut up because cellmate playing TV too loud. Officer escorting expressed concern that he was not eating much and generally neglecting himself. The man states that he eats well, contrary to the officer."

The Staff Nurse made a referral via the medical computer system (SystmOne) back to one of the Registered Mental Health Nurses.

54. Around 11.50am on 9 September, the man attended an ACCT review meeting with Seniors Officers from the houseblock and the Safer Custody Team. His level of risk of self-harm was recorded as "raised". The following entry was made in the summary of the review:

> "The man explained that he couldn't cope and have made some slight laceration to his left wrist, observations increased to twice hrly (hourly), plus conversations am/pm/ed [morning, afternoon and during the night]. Awaiting further input from medical from this afternoon's MDT

55. The man's case was not discussed at the MDT meeting on 9 September and there is no explanation for this oversight in his records.

56. A volunteer from the prison chaplaincy visited the man during the afternoon of 9 September. The following entry was made in the ACCT record after his visit:

> "The man told me he didn't realise that the Muslims fasting were eating at night, which is why he has lost so much weight. He is eating three times a day now and looks much better for it."

57. From conversations with staff, it appears that the man had become friendly with a fellow prisoner who was fasting for religious reasons. To show his support for his fellow prisoner, the man had also stopped eating. However, it appeared that the man failed to realise that his fellow prisoner was only fasting during the day. In his statement to the police, the prisoner who had been fasting wrote:

> "I took him to get his medication and food and generally took care of him. I saw him most days in the mornings when the cells were opened and in the afternoon when cells opened. I am a religious guy and he wanted to join my religion and due to Ramadan, he began fasting and stopped eating. I told him he needed to eat but he kept saying he wanted to follow my religion."

58. During the morning of 10 September, the man's cellmate left the prison to go to court. He did not return to the prison. (Staff subsequently discovered three days later on 13 September that the man's cellmate had been released by the court.)

59. Around 11.20am on 10 September, the man attended an ACCT review meeting with a Principal Officer and an officer from the houseblock. Following his ACCT review, the man's risk of self-harm was reduced from "raised" to "low". The following entry was made in the summary of the review:

> "The man fully engaged with the review process. He indicated that he no thoughts of self-harm since he cut himself yesterday. He is beginning to understand how the prison system works but still needs help in this area. He attends the library on a regular basis and had made a few friends on his spur. He has started to eat and is sleeping a bit better. Healthcare do not have any immediate concerns regarding his mental health, although a psychiatric appointment is pending. I have tasked the man to apply for a job today and ask for a PIN[5] number as he has misplaced his original one. ACCT to remain open until results of the psychiatric assessment."

60. A care and management plan (Caremap) was drawn up after the ACCT review and three goals and related actions were established. The Caremap was signed by the man and the Principal Officer. Each of the goals related to keeping the man safe and the related actions were:

- To arrange for the man to apply for a PIN number so that he can use the prison telephone system to contact his family.
- For the man to have a mental health assessment with the psychiatrist.
- To occupy the man's time either through seeking employment or attending education.

61. When interviewed for this investigation, an officer confirmed that the staff at the ACCT review would not have known whether the man's cellmate would return from court. This would not become apparent until after 8.00pm when all the prisoners would have returned. He confirmed that they had considered putting someone else to share with the man on 11 September but decided against it. This was because of his vulnerability and they also felt no other prisoners were suitable to go in with him. Also they did not know whether his cellmate might return to the prison the following Monday (13 September).

62. The officer said that the man's safety was the most important factor and his behaviour during the weekend gave staff no cause for concern. He also stated that if the man's risk of self-harm had been recorded as "high", then staff would have "looked at" moving another prisoner in with him. The officer confirmed that the man collected his meals at the weekend and did not throw his food away. The officer said: "I was quite happy with the way things were going with the man."

[5] Pin telephones are used in prisons and each prisoner is given a PIN number which they key in before making a call. Prisoners may 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.

63. At around 8.45pm on 11 September, an Operational Support Grade (OSG) commenced his night duty. He was on duty by himself on the houseblock. The OSG recorded the following entry in the man's ACCT plan at around 9.05pm "First check of shift sat on bed reading a book". The next entry by the OSG was around 11.00pm when he recorded that the man was sitting on his bed watching television. There followed a routine check at 11.35pm by the Night Orderly Officer[6] which was also recorded in the ACCT plan.

12 September

64. At around 1.00am on 12 September, the OSG entered the following entry "Sat on bed watching TV stated he was fine". The next entry at 3.00am recorded that the man appeared to be asleep. At around 5.00am, the OSG made a further entry "Sat on bed watching TV no concerns stated he was okay."

65. The next ACCT check was at about 6.45am. The OSG checked on the man and found him hanging from a ligature (made from a bedsheet) attached to the toilet cubicle door in his cell. The OSG did not go into the cell but instead used his radio to summon assistance. He was advised by the Night Orderly Officer to wait for her arrival before entering the cell.

66. When interviewed as part of this investigation, the OSG confirmed that he shone his torch on to the man's bed and saw that he was not in it. He then shone the torch round the corner of the cell and saw that the man was near the toilet. The OSG tried to elicit a response from the man and then turned on the cell light. He noticed that the man's blanket was hanging over the toilet door. The OSG then summoned assistance using the radio call sign for an emergency relating to breathing problems (Code Blue). The OSG said: "I couldn't see his face very clearly and that is one of the reasons why I never entered the cell, because I couldn't see his face. So I didn't know if it was a genuine hanging."

67. When interviewed as part of this investigation, the Night Orderly Officer confirmed that she did not give permission for the OSG to go into the man's cell. Her caution was due to safety and security concerns as she was quite a distance away from the houseblock. She said that she would not permit a single OSG to go alone into the cell in case the prisoner was faking. Had she been close by, she said that she would have agreed to him going in alone.

68. The Night Orderly Officer and her assistant arrived at the cell within a few minutes of the call for assistance. They entered the cell and the assistant attempted to cut the sheet with an anti-ligature knife[7]. However, this proved too difficult to achieve as he man had used the whole sheet and so the staff had to lift him to take his weight. The Night Orderly Officer and her assistant, assisted by the OSG, lifted the man so that the bed sheet was released. After the sheet was removed, the man was laid on the floor of the cell.

[6] The Night Orderly Officer is the person in charge of the prison at night time.
[7] Anti-ligature knives, also known as 'fish knives' or 'cut down tools', are specially designed to cut ligatures.

69. As the Night Orderly Officer and her assistant attempted to find a pulse, they were joined by healthcare staff who commenced cardio pulmonary resuscitation (CPR). The man was connected to a defibrillator which indicated that there was not a shockable rhythm. (Defibrillators deliver a brief electric shock to the heart, which enables the heart's natural pacemaker to regain control and establish a normal heart rhythm. The defibrillator is an electronic device with electrocardiogram leads and paddles. During defibrillation, the paddles are placed on the patient's chest, staff stand back, and the electric shock is delivered.)

70. The paramedics arrived at 7.15am and took over the man's care. The ambulance left Hewell at 7.50am and the man was taken to the Accident and Emergency (A&E) Department at the local hospital. He was accompanied by two officers but restraints were not used. The man was pronounced dead by a hospital doctor, at 9.32am.

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

72. The prisoners were informed of the man's death during the morning of 12 September. They were also asked whether they required any support or wanted to speak to a Listener. All the prisoners on ACCT monitoring were reviewed.

73. After a death, 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 how staff can support each other. The Head of Operations at Hewell held a hot debrief during the morning of 9 July. There were no areas of concern raised at that time but the staff who tried to resuscitate the man were offered support from the prison's care team. As notes of the meeting 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 incident.

74. After the man passed away, the Head of Operations and member of the chaplaincy visited his family to inform them about his death.

75. Hewell appointed a prison family liaison officer. She 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 24 September 2010.

76. After the man's death a post mortem examination was carried out by a Forensic Pathologist. In the post mortem report, he records the man's death as being due to hanging. The report says:

> "I gathered that the deceased had a long history of alcohol abuse and alcohol abuse seizures. He had thoracic cervical discitis [inflammation of the spine]. He took an overdose of sertraline in 2008. In 2009 he

had episodes of haematemesis [vomiting blood] caused by his alcohol abuse."

There was no information about the man taking an overdose of sertraline in 2008 in the records seen by the investigator and clinical reviewer.

ISSUES CONSIDERED

77. As mentioned earlier in the report, the man's family were contacted by the Ombudsman's family liaison officer. The family wondered how the man had been whilst he was in custody, whether he had kept to himself or had any problems at all. The family were aware that he had been subject to the ACCT self-harm monitoring and support procedures and wanted to know more about this process. I hope that this has been addressed within the main body of the report. After receipt of the draft report the man's family drew attention to the correspondence they forwarded to the man's GP, the police and local mental health services where the raised concerns about his mental health. This information had not been passed onto Hewell by these agencies when the man was received into custody. The Head of Healthcare at Hewell confirmed that the man's GP was contacted but a response was not received from them. Although this may not have affected the outcome in this case, as measures to support the man were put in place, it is important that requests for information are followed up.

Clinical care

78. The family also wanted to know more about the man's medical care. As noted, a review of the man's medical care was undertaken by a doctor on behalf of Worcestershire Primary Care Trust. 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 his review the clinical reviewer finds the man's assessments and reviews to be:

> "… detailed and comprehensive, and initial responses by prison officers and healthcare staff appear to be prompt and supportive, including an early decision for mental health assessment and psychiatric review."

79. The clinical reviewer finds these initial assessments to be at least equitable to what is available in the community. However, he draws attention to the apparent failure to discuss the man at the healthcare multi-disciplinary (MDT) meeting on 9 September and the man's missed doctor's appointment on the same day. The episode of attempted self-harm that morning raises issues regarding communication within the healthcare team and between them and discipline staff. The healthcare staff who had recommended discussing the man at the MDT meeting were unavailable on the day or at the time of the meeting.

80. Officers completing the ACCT plan were expecting that the man's mental health was being reviewed and they appeared unaware that this had not taken place. The clinical reviewer wrote:

> "It is conjecture if the man's death would have been prevented if these reviews had taken place. Initial concerns in the ACCT appeared to be more related to physical health issues. According to the ACCT documentation he had shown signs of improvement and engagement

the day before his death and he had been seen and had stated that he was okay less than two hours prior to his death."

81. The clinical reviewer states that, in view of the perceived improvement recorded in the ACCT plan, the observations could have been reduced or the man could even have been removed from the ACCT process. In the clinical reviewer's opinion, despite the man's mood fluctuations, there is no evidence to suggest the likelihood of his observations being increased to constant watch[8]. He was also assessed as being fit to remain on the houseblock and not move to the healthcare centre. However, the failure to discuss the man at the MDT meeting resulted in there being no new plan or actions which reduced the opportunity for further actions to be taken.

82. The clinical reviewer concludes that, had the man's care been discussed at the MDT meeting on 9 September,

> "This could have been considered an appropriate and timely response and one that is equitable with that in the community.

The reviewer considers that the failure to discuss the man at the MDT meeting should be addressed. As he says, there should be a review of procedures and policies to ensure that prisoners are discussed even in the absence of key workers or other staff involved in their care.

The Head of Healthcare should review the procedures for reviewing the mental health needs of prisoners to ensure that referrals are followed up and appropriately actioned.

83. The clinical reviewer also draws attention to the lack of response to the man's failure to attend a doctor's appointment on the same day that he harmed himself. He writes:

> "The non-attendance of a prisoner on an ACCT, particularly one who has recently attempted self harm, should be highlighted and prompt risk reassessment made including reference to review."

I agree with the clinical reviewer, it is important that ACCT monitoring includes attendance at medical appointments. I appreciate that prisoners who are mentally capable of deciding whether to accept medical treatment are entitled to decide for themselves whether or not to go to appointments. However, prisoners who are at risk of harming themselves should be encouraged to accept treatment. Missing an appointment should be a trigger for an ACCT review, which should include healthcare staff. .

The Head of Healthcare should review the monitoring systems for missed medical appointments when a prisoner is subject to self-harm and suicide

[8] Whenever a prisoner is deemed to be at high risk of suicide or self-harm, an officer sits outside the cell and observes the prisoner. Unlike the normal cells, the doors are not solid and have vertical bars instead. Covering the bars is a clear perspex sheet allowing observation into the cell.

procedures. An ACCT review should be arranged and healthcare staff should attend.

Prescribing sertraline

84. As mentioned earlier in this report, following a consultation with a prison doctor, on 28 August, the man was prescribed sertraline (an anti-depressant). Neither the clinical reviewer nor my investigator could find any evidence that a discussion took place about the side effects of this medication and certainly nothing was recorded on the man's notes.

85. One rare side effect of sertraline is increased suicidal thoughts. This could have had a direct bearing on the man's behaviour after he started taking the medication. If a discussion about the possible side effects had been recorded, other healthcare staff would have known and could have acted upon the information accordingly. It is vitally important that staff to record these types of discussions with prisoners in the medical record.

86. I suggest that consideration should have been given as to whether it is sensible to prescribe sertraline to someone who has already harmed themselves. I have seen no evidence that healthcare staff attended the man's ACCT reviews and so I do not think that the risk from the medication was considered. I comment on this in the next section of my report.

Use of Assessment, Care in Custody and Teamwork procedures

87. 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 in this case the man was being monitored correctly by wing staff after concerns were raised about his well being on 7 September.

88. Although the appropriate wing staff were at the man's ACCT reviews, I think that the discussions would have benefited from healthcare staff being present. As the ACCT guidance says, regular multi-disciplinary case reviews should take place. The man had been referred to the mental health team and was taking anti-depressant medication. He was waiting to see a psychiatrist. I think that healthcare staff should have been part of the ACCT monitoring.

The Safer Custody Manager and Head of Healthcare should work together to ensure that healthcare staff attend ACCT reviews, especially when a prisoner should be receiving treatment.

89. Following the man's self-harm the level of observations was increased to twice hourly. However, as he was engaging with staff the decision was taken to lower his level of risk from "raised" to "low" on 10 September, just two days before the man took his own life. However, despite reducing the level of risk, the level of observations remained the same. The fact that he was alone in his cell following the release of his cellmate may well have been a factor in

retaining the same observations. However, I think that leaving the man alone in his cell should have been given more consideration. His cellmate had not returned to the prison on 10 September after a court appearance but staff were reluctant to put someone else into the cell. This was because of the man's own vulnerability and as he appeared to be coping better. I appreciate that two more days passed before the man took his life and so I make no recommendation. However, I suggest that the Governor may wish to remind staff that any change of circumstance of a prisoner subject to ACCT support should be considered in relation to the level or risk and appropriately recorded.

Actions taken by Hewell after the man's death

90. On 12 September, staff who had been on duty during the night and who were returning to work that evening were not informed of the death by the prison. When the man left the prison in an ambulance, the night staff would not have known whether their attempts to resuscitate him had been successful. Hewell was informed around 9.40am that the man had passed away. Police officers attended the prison soon after to visit the man's cell and interview staff. They were informed that the night staff had already left the prison. However, no attempts were made to inform them of the death or that the police wanted to interview them.

91. During the afternoon of 12 September, the Night Orderly Officer and the OSG were both telephoned at home by the police who told them of the man's death. The police then informed them that they would visit them at home to take their statements. The OSG was on his rest days after he finished his overnight shift during the morning of 12 September. The Night Orderly Officer finished her night shift on the morning of 12 September and was due to return to duty the same evening. She was contacted by the police during the day and was interviewed prior to returning to work another night shift.

92. The police had been in contact with the prison to obtain the Night Orderly Officer's contact details and it appears that no one thought to tell them that she was due to return to work that night. As a result she had worked a very difficult night shift followed by interrupted sleep and an interview with the police. She then returned to work another night shift.

93. Where a death occurs during the day, staff involved in the incident are often sent home and may not be expected to return for duty the following day. It seems that the same considerations did not apply when the death occurs during the night. The Governor may wish to give this matter some consideration to ensure the welfare of staff whether they work during the day or the night.

CONCLUSION

94. The man arrived at HMP Hewell on 23 July 2010. Before he arrived in custody, the man's family contacted his GP, the police and the local mental health services to raise their concerns about his mental health. This information was not passed onto Hewell after the man was received into custody. On 7 September, ACCT self-harm monitoring procedures were put in place after staff raised concerns about the man not eating, his weight loss and his mental health. Two days later, on 9 September, the man told staff that he had cut his wrist and he was treated by healthcare staff.

95. I am generally satisfied that the ACCT procedures were used properly and I make no criticism of the decision to reduce the level of risk on 10 September. However, I do consider that healthcare staff should have been part of the ACCT support and monitoring arrangements especially as the man missed one doctor's appointment, was waiting to see a psychiatrist and was taking sertraline (which albeit rarely can increase the risk of suicidal thoughts).

96. In the days leading up to his death, the man appeared to be interacting with staff and was eating properly again. His cellmate left prison and so the man was alone in his cell. Two days later, during the morning of 12 September, the man was found by staff hanging in his cell. He was taken to a local hospital where he died shortly afterwards.

97. In his review, the clinical reviewer draws attention to the failure for the man's care to be discussed at the healthcare multi-disciplinary meeting on 9 September. He also draws attention to the failure to follow up the man's non attendance at a doctor's appointment on the same day of his reported act of self-harm. The clinical reviewer concludes:

> "I felt that the man's care up to the days preceding his death was equitable with the care he would have expected to have received in the community. However, there were failings in communication in his last few days which did not meet the standards of care expected."

In light of the findings of my investigation and the clinical review, I conclude that the healthcare provided to the man was equitable to that he would have received in the community.

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 Head of Healthcare should review the procedures for reviewing the mental health needs of prisoners to ensure that referrals are followed up and appropriately actioned.

   Recommendation accepted - New meeting structure is now in place to ensure that referrals are appropriately managed and discussed in the appropriate forum. The Threshold Assessment Grid (TAG) process has been audited.

2. The Head of Healthcare should review the monitoring systems for missed medical appointments when a prisoner is subject to self-harm and suicide procedures. An ACCT review should be arranged and healthcare staff should attend.

   Recommendation accepted - Mental Health DNA's (Did not attend) are routinely rebooked by the nurse expecting to see the patient at the time of the original appointment. However, work is underway to introduce a 'flag' system on the on the Healthcare data base (System1) to ensure that patients are actively sought following the second missed appointment.

3. The Safer Custody Manager and Head of Healthcare should work together to ensure that healthcare staff attend ACCT reviews, especially when a prisoner should be receiving treatment.

   Recommendation accepted - Agreed that healthcare staff should attend all ACCT reviews for patients in the patient unit, and prisoners who are actively being managed on the active case load of the mental health team. Arrangements to achieve this are already in place. Safer Custody and Healthcare have an arrangement where a mental health nurse can be contacted to attend an ACCT review where they feel there are concerns.