Investigation into the death of a man in January 2006, whilst in the custody of HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

July 2006

This is the report of an investigation into the death of a man who died in North Manchester General Hospital on 5 January 2006, about 40 hours after he had been found in the gated cell of Manchester prison's Healthcare Centre with a ligature round his neck. He was being monitored under the Assessment, Care in Custody and Teamwork (ACCT) arrangements which are put in place for prisoners thought to be at risk of suicide or harming themselves. This man was 28 years of age.

I offer my sincere condolences to his family and friends.

The investigation was carried out by one of my team leaders, assisted by one of my investigators; one of my Family Liaison Officers made contact with the man's family. I hope that this report helps to explain the circumstances in which he apparently took his own life.

North Manchester PCT reviewed the healthcare this man received during the short time he was at HMP Manchester. Their assistance is much appreciated. The PCT has made several recommendations, which I endorse.

I would also like to thank the Governor of Manchester prison for his help. I am grateful too to those of his staff who were involved in the investigation, particularly a Principal Officer.

The man had been diagnosed with severe mental illness at least seven years before his death. He had been compulsorily detained for treatment and had made earlier attempts on his life. He had also spent a previous period in custody at HMP Manchester.

On this occasion, the man was remanded in custody on 16 December 2005. His mental health needs were recognised on reception and, after a period on a normal wing, he was admitted as an inpatient to the prison's Healthcare Centre. However, despite being placed in a 'safer' cell and being closely monitored, he managed to cut his arm. As his cell required extensive cleaning, he was moved to the only available cell which was not a 'safer' cell. I am concerned that neither the act of self-harm, nor the move to the relatively unsafe cell, led to the ACCT arrangements being reviewed or the level of observations being increased.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2006**

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Summary

1. The man at the centre of this investigation was young with a long history of serious mental illness. He had made at least one earlier suicide attempt, and had served a previous prison sentence. On this occasion, he was remanded into custody for sentencing having been convicted of using threatening words and behaviour. He arrived at HMP Manchester on 16 December 2005.

2. When the man arrived at the prison's reception, he said he had missed the last five days' anti-depressant medication. The doctor thought that he had been exceeding the recommended dosage and reinstated the prescription. He was allocated to a normal wing. However, there were several occasions towards the end of December when he was disruptive.

3. On New Year's Eve, wing staff became concerned about the man's mental health as they found him agitated, angry and disruptive. They arranged for him to be assessed by a psychiatric nurse and he was admitted to the prison's Healthcare Centre. The nurse also opened the Assessment, care in Custody and Teamwork (ACCT) document used to monitor prisoners at risk of suicide or self harm. The man was initially placed in an ordinary cell and the level of observations was four times every 24 hours.

4. An ACCT review took place the following morning (New Year's Day) when the man reported that he was hearing voices telling him to kill himself. The level of observations was increased to intermittent (five times per hour), and he was moved to a 'safer cell' (that is one with reduced ligature points). Anti-psychotic medication was prescribed.

5. During the evening of 2 January, the man cut his arm. Although the injury was slight, he lost a lot of blood and his cell required industrial cleaning. First aid was administered and the nurse in charge assessed that he was at no further risk to himself. The man was moved to the only vacant cell - the gated cell, which is not a safer cell - and the level of observations remained the same.

6. The man was interviewed the next afternoon (January 3) by the prison's psychiatrist who remembered him from his earlier sentence and was aware of his mental health history. The man said that he had harmed himself before and threatened to kill himself now if his medication was not increased. He said that he was still hearing voices telling him to kill himself. The psychiatrist increased the dose of both anti-depressant and anti-psychotic medications, but only the latter could be administered as he had already received the daily dose of the first. The psychiatrist also confirmed that the man should remain in the gated cell with intermittent observations.

7. Eight hours later (just before midnight on 3 January), the man was found by an officer during a routine observation having apparently hanged himself from the window bars. Staff responded promptly and effectively. The man was taken to hospital where he was operated on, but sadly his life could not be saved. His

family agreed that the life support machine should be turned off 40 hours later on 5 January 2006.

Conduct of the Investigation

8. The investigation began on 9 January 2006 with a visit to HMP Manchester. My colleague met the Governor, the Head of Healthcare, and representatives of the Independent Monitoring Board. Notices were displayed to announce the investigation and invite prisoners and staff to contact the investigator. Prison records, including medical records, were also made available together with relevant prison policies and procedures. The ACCT guidance for staff was referred to.

9. A Clinical Review was commissioned from North Manchester Primary Care Trust and was carried out by a clinical reviewer there.

10. Following the initial visit, 19 staff were interviewed on various dates, either face to face or by telephone. Those interviewed were either involved in the man's reception and induction to the prison, worked on K wing or the Healthcare Centre or took part in the bedwatch arrangements. The interviews with healthcare staff were led by the clinical reviewer, accompanied by one of my investigators.

11. Informal conversations took place with four of the prisoners who were also in the Healthcare Centre when the man was there.

12. My assisting investigator visited the man's mother and sister together with one of my office's Family Liaison Officers. The family raised the following questions and concerns:
    - Lack of observations by staff in the Healthcare Centre. For example, the man's family had heard from another prisoner that a cell had been flooded and staff had not noticed for some time. They had also been told that an unnamed member of staff was continually absent from the wing when he or she should have been on duty.
    - They asked for the names of the staff on duty in the Healthcare Centre on the night that the man was found hanging.
    - They said the man should have been watched more often and that the assessment of intermittent watches was wrong.
    - The family asked whether the prison located the man's earlier records to ensure that he was given the most appropriate care during this period in custody.
    - They asked whether the man cut himself on his wrist or his elbow as they had been given different accounts.
    - They asked what the man used to cut himself and whether it was removed from his possession.
    - The family said the decision to move the man from a 'safer' cell to one with a ligature point was unacceptable.
    - It was also unacceptable that the reason given for moving him was that the cell needed cleaning; alternative cleaning arrangements should have been made.

- They asked what happened when the man saw a mental health professional, said that he was schizophrenic and asked for his medication to be changed.
- The family wanted to know what medication was prescribed and whether Ian had his own supply or if it was dispensed daily.
- They asked what the man disclosed at reception about his previous history and whether he saw a doctor.
- They said pneumonia was identified on the temporary death certificate and asked whether the prison was aware of it.
- They asked what the man said to other prisoners.
- When the family visited the prison, they thought that the governor made inappropriate comments about the man, and also about suicidal people in general.
- They asked what the man was wearing when he was found, where the clothes are now and what has happened to the ligature.

Background

13. This man was received at HMP Manchester on 16 December 2005 having been convicted by Manchester Magistrates' Court of the offence of using threatening words and behaviour. He was a resident at a hostel at the time, following a period of housing instability.

14. He had struggled with feelings of depression throughout his twenties and had harmed himself previously. His emotional difficulties appear to have been made worse by his use of alcohol which also contributed to his offending. On more than one occasion, he had been admitted to hospital under the Mental Health Act (1983) for his own safety.

HMP Manchester

15. HMP Manchester is a dual purpose local and high security prison. The top section operates as a local prison for men from the Greater Manchester area, and the remainder is for prisoners from all over the country. The man in this report was situated on K wing until his transfer to the Healthcare Centre.

16. The Healthcare Centre's inpatient unit is a 35 bed facility for prisoners with either physical or mental health needs, many of whom are assessed as at risk of suicide or self harm. The beds are included in the prison's Certified Normal Accommodation, and healthcare beds can be used for non-medical patients if residential units are full.

17. Prisoners are responsible for cleaning their own cells and there is a regular morning routine for cleaning materials to be provided so that the cells can be swept and mopped. Any other cleaning is done by outside contractors.

18. Within the Healthcare Centre access to shaving materials is restricted and prisoners should only have them under supervision.

19. The Healthcare Centre contains four of Manchester's five 'safer' cells which have been adapted to remove ligature points. The man was located in one of the safer cells, MY10, from 31 December until 2 January 2006.

20. The Centre also contains a gated cell, MY7, which is located directly opposite the office, and where the man was moved on 2 January. This cell meets earlier standards for safer cells and has safe furniture, including a television behind a perspex screen which is inaccessible from within the cell. However, there is a normal window with bars, and it is from these that the man apparently hanged himself on 3 January. The cell has a normal cell door with an observation panel and a full-length gate covered with perspex. Either the door or the gate can be locked in place. There is a protocol for the use of the gated cell that requires that:
    - the gate should be in place;
    - prisoners should be constantly observed by a staff member seated at the gate;

- a register should be completed;
- the Independent Monitoring Board should be notified;
- an early review should take place.

The protocol was not implemented when this man was placed in the cell and he was monitored intermittently, that is not less than five times per hour at irregular intervals.

21. The inpatient unit is staffed by a combination of healthcare and discipline staff, all of whom are employed by the prison. Staff from both disciplines were interviewed for this investigation and spoke positively about their working relationship and the exchange of information between them. There is a joint handover meeting at the beginning of each shift, followed by a healthcare staff discussion of confidential medical matters. All staff use the prisoner's history sheet to record shared information, and the medical record is used for additional confidential medical information. Decisions about a prisoner's location are the responsibility of the senior nurse on duty at the time, subject to any security concerns of discipline staff.

22. Adjacent to the Healthcare Centre is a small courtyard, which is part of the Segregation Unit, and is available for inpatients who wish to exercise there during association times. There is also a large association room with television and pool table. City College, Manchester, holds education classes every weekday, with space for ten prisoners. Any of the inpatients may apply for a place, but must be risk assessed and complete a screening test. The places are allocated chronologically on a six month rotation, so that short term patients have little prospect of getting a place. The class caters for the full range of educational ability and there is no special provision for prisoners with a psychiatric illness.

23. During the night, the prison is in patrol state which means that prisoners are locked in their cells and fewer staff are on duty. One officer and two nurses are on duty during the night in the Healthcare Centre. The nurses are also responsible for a range of routine administrative tasks for the following day's clinics. These are undertaken in the ground floor offices of the Centre and take them out of the inpatient unit for up to five or six hours at a time. The nurses are also required to attend any healthcare emergencies in other parts of the prison.

24. The prison has a Mental Health In Reach (MHIR) team which is part of the Manchester Mental Health and Social Care Trust. It employs specialist psychiatric staff including a full time psychiatrist. The team provides individual support for prisoners on the wings, and group activities for those with specific needs such as auditory hallucinations. Prisoners referred to the MHIR team who are subsequently admitted as inpatients in the Healthcare Centre may continue to attend the groups, but they are not generally available to other inpatients.

25. The last full announced inspection of Manchester prison by Her Majesty's Chief Inspector of Prisons took place in July 2004. The report says that the

inspectors found the prison to be a more stable and purposeful environment than at previous inspections.

26. During the two years prior to this man's death, there were nine deaths at Manchester, eight of which were apparently self-inflicted.

Assessment, Care in Custody and Teamwork (ACCT)

27. As at many prisons, ACCT has recently been introduced at HMP Manchester to monitor and support prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals:
    - four times or more, or at least four times in 24 hours including at least one quality entry;
    - intermittent, which is not less than five times per hour at irregular intervals;
    - constant, where the prisoner is observed by a designated member of staff who remains constantly in his presence (in accordance with each establishment's local strategy).

    The observations of healthcare inpatients who are on ACCT are shared by nursing and discipline staff; at night-time, officers are generally responsible.

28. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care. Manchester prison has a rota of trained ACCT assessors who attend reviews, together with staff from the part of the prison where the prisoner is located. The key questions for each review are listed as:
    - Have the problems that caused the ACCT plan to be opened now been resolved?
    - If not, what needs to be done to resolve them?
    - Have any further problems arisen that are now causing distress and more risk?
    - If so, what action can be taken to address these?
    - Is the person at risk now in contact with friends, family or other support?
    - Does the person at risk now have something in their lives that they feel good about?
    - If not, how can this be improved?

29. Over time, the reviews should also consider other factors such as:
    - Distress – has anything changed to make the person at risk more or less desperate?
    - Resources – has anything changed that makes the person at risk now feel more or less alone?
    - Previous Suicidal Behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
    - Suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
    - Pattern of self harm – is self harm becoming more or less frequent?

30. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment and it is for the Case Review team to decide the most appropriate place to locate an individual prisoner.

Key Findings

16 – 30 December 2005

31. The man was received at HMP Manchester on 16 December 2005, having been convicted by Manchester Magistrates' Court of using threatening words and behaviour. He was remanded into custody for sentencing until 13 January 2006. A Prisoner Escort Record (PER) form was completed by the escort staff who recorded that the man had unconfirmed schizophrenia and presented as vacant. The seventh question on the PER form asked whether there was an open F2052SH in place. The response was that there was currently an open F2052SH, but one had not been opened on previous sentences. It was not clear what action was taken in respect of the open F2052SH. The PER form identified two risks, a medical risk due to his mental condition, and a security risk of violence.

32. The man arrived at the prison at 4.20pm and went through the First Night Induction, which is a two-stage process, comprising interviews with an officer and a nurse. During the interview with the officer, the man denied having feelings of depression or suicidal ideas and said that there was no reason for concern. He disclosed that he had previously injured himself, saying that he cut his wrists a "few years ago". There were no concerns about his physical health. The Cell Sharing Risk Assessment (CSRA) assessed the risk he presented to other prisoners as Medium, which means that there was no immediate risk, but the situation needed to be reviewed regularly. The man said that he was of no fixed abode and gave no address for his next of kin.

33. The nurse carried out the health screening, which took place in a private room for between ten and 15 minutes. When interviewed for this investigation, the nurse said that he did not recall the interview and the information was obtained from the record. He noticed that the man had some facial injuries, scratching to his abdomen and bruising to his body. He described the man as being anxious and agitated, with poor concentration and a low mood. The man disclosed that he had slashed his wrists two years earlier whilst in the community. He said that he was currently prescribed Citalopram, which the nurse knew was for depression, but said that he had exhausted his supply five days earlier. The man told the nurse that he no longer felt like harming himself and so the nurse did not consider that an ACCT form should be opened.

34. The nurse decided to refer his patient to the MHIR team, and arranged for him to be seen by the doctor on duty, a locum who worked regularly at the prison. The man gave the same information to the duty doctor as he had given to the nurse. He said that he was agitated but the doctor considered that he appeared relaxed and calm. The doctor identified that the man had run out of his medication because he had exceeded the recommended dosage. He re-instated the prescription but refused permission for him to hold it himself until he was assessed by a psychiatrist.

35. In fact, at no time during the man's period in custody was he permitted to hold his own medication. Whilst on the wing, it was administered by nurses in the treatment room. When he moved to the Healthcare Centre, nurses administered his medication at his cell door.

36. Although the duty doctor wrote the prescription on 16 December, the clinical reviewer has identified that it does not appear that the man actually received the drug until 21 December. From that date onwards, the man received all medication as directed including any amended doses and additional drugs.

37. The man was located on G Wing, which is where the majority of new arrivals to Manchester are held.

38. On 19 December, the man signed Manchester's Prison Compact, which explains the code of conduct that prisoners are expected to adhere to. On 24 December, an officer completed the man's induction to the prison in a class with seven or eight other men. She said that she aimed to make it an informal occasion, encouraging prisoners to interact together. She did not know anything about the prisoners' backgrounds, offences or sentences. She remembered that the man was quiet, a little irritable and she thought that he was probably a bit depressed and that it could be his first time in prison. She did not think that he had any mental health needs.

39. This officer was on duty on G wing on Christmas Day, when she said that a colleague told her that he was concerned that the man might be being bullied. The other officer had noticed other prisoners coming and going from his cell carrying tobacco. The female officer therefore spoke to the man in his cell. She had noticed that he had not joined in any of the Christmas activities and wondered if he might be feeling down. She told him that he could come and talk to her if he felt like talking. The officer saw him later in the day when carrying out a roll check, and he told her that he was not being bullied. She advised him to keep his tobacco out of sight of other prisoners. She recalled asking another officer to keep an eye on the man when she went off duty, but was not sufficiently concerned to take any other action or to make a record of the conversations.

40. On 29 December, officers returned the man to his cell after he ignored their warnings about repeatedly standing on the landing. Later that day, the wing history sheet noted that when the cells were being locked the man waited at the door and tried to slam it into another officer.

41. The next day, the man's CSRA was reviewed before he was moved to K wing, which is also part of the prison's normal location. On this occasion, the risk was reduced to Low. A Senior Officer (SO) gave him a verbal warning about the incidents the previous day.

31 December

42. Over the course of the following day, 31 December, the man's behaviour became increasingly disturbed. During association, the cells were unlocked

and he repeatedly slammed his door, prompting a second officer to order him to stop. She recorded that he gave her strange looks when she locked him in his cell, and that she found them threatening. The second officer spoke to her colleague, a third officer, who also went to speak to the man to see if he could calm him down.

43. The third officer said that the man presented as irritable, agitated and fidgety, and he was concerned about the possibility of mental disturbance. He described the man as frustrated, rather than angry, and giving the impression of wanting to be locked up again. In the third officer's experience, prisoners behaving like this man, by slamming their unlocked doors, may do so because they are being bullied. He considered whether the man was being bullied, but could find no evidence, and so was even more concerned about his mental health as there was no obvious explanation for his behaviour. After spending some time talking to the man, the third officer thought that he should be locked in again. He told the man that he would lock the cell whilst he went to sort things out, and the man then became quiet.

44. The third officer spoke to another SO, who was also concerned about the man's mental well being, and spoke to Healthcare Centre staff. At first, wing staff were told that the doctor's assessment was that the man was fit for normal location. However, later on it was arranged that the man should be assessed by healthcare staff.

45. At about 4.30pm, the other SO escorted the man to the Healthcare Centre where a Registered Mental Nurse (RMN) interviewed him. Before the interview took place, this SO told the RMN that the man's behaviour was odd, and he had been pacing the cell and kicking the door. The man told the RMN that he was hearing voices telling him to slash his wrists and hang himself. He also said that he had a history of schizophrenia and depression and had been diagnosed with a personality disorder. She assessed him as low in mood, that he made little eye contact and said that he did not want to live. She said that she did not think that he had told her everything, and was also concerned that he was not receiving any medication for schizophrenia.

46. No concerns about the man's physical health were noted and there was no suggestion that he was suffering from pneumonia, either when he arrived at the Healthcare Centre or at any subsequent time.

47. After talking to the man, the RMN spoke to the lead Registered Mental Nurse in the Healthcare Centre. They decided to admit the man as an inpatient so that he could be observed and a more thorough assessment of his mental state conducted. He was not admitted for self- harm reasons. The RMN said that, at the time of the man's admission, no safer cells were available as they were all occupied by prisoners who could not be discharged. He was initially admitted to cell X4 which is not a safer cell.

48. Because of her concerns about the man's condition and history of self-harm, the RMN and the lead RMN also decided that ACCT procedures should be put in place. The RMN drew up an initial care plan for the following 24 hours.

She and the lead RMN agreed that the man would remain in an ordinary cell, with access to a Listener (a confidential support service provided by the Samaritans) and access to the telephone to the Samaritans. He was to be observed by staff on no fewer than four occasions each 24 hours and staff were also expected to actively engage the man in at least one meaningful conversation during the 24 hours. After being admitted, the man was quiet and there was no repetition of the disturbed behaviour evident on the wing.

49. As the RMN was due to be on duty during the next few days, and did not have many named patients, she agreed to be the man's named nurse. She continued to draw up the nursing care plan, but said that some sections were incomplete as the man refused to speak to her which she intended to rectify the following day.

1 January 2006

50. The next morning the duty ACCT assessor, an SO, came to the Healthcare Centre to attend the ACCT review. She worked in a different part of the prison and had not met the man previously. She talked to one of the nurses to find out about him, prior to interviewing him at about 9.30am to explain the review process and ask him how he felt. The interview took place at one end of the association room and the duty ACCT assessor said that other prisoners, whom she thought were wing cleaners, were present at the other end but out of earshot. The duty ACCT assessor said that the man was quiet and she asked him to speak up and look at her so that she could hear. He told her that he had harmed himself by cutting his wrists the previous year and that he was feeling fed up and angry. He went on to say that he was hearing voices which told him to kill himself.

51. The ACCT review was at 11.00am and the man attended, together with the duty ACCT assessor, the lead RMN and a Healthcare Officer (HCO). The HCO had not met this man prior to the review, and was present at the request of the lead RMN. I am surprised that the original RMN was not present at the review. She was on duty that day, had previously assessed the man to open his ACCT document, was his named nurse, and had begun to draw up the nursing care plan.

52. The HCO described the man as quiet and subdued during the review. During the discussion, it was decided that the risk of his harming himself was increased to Raised, which the ACCT document defines as occurring when:
- *suicidal ideas are frequent but generally fleeting*
- *no specific plan/immediate intent*
- *evidence of mental disorder*
- *significant alcohol or drug abuse*
- *situation experienced as painful but no impending crisis*
- *previous, especially recent, suicide attempts*
- *current self-harming behaviour.*

In this man's case the first five factors were applicable at the time of the review.

53. The review was interrupted as the duty doctor was available to see the man; this doctor is a locum doctor who regularly works at the prison. The duty doctor noted the man's thoughts of hanging himself, but thought that there was no evidence that he had definite plans to do so. The doctor prescribed a low dose of an anti-psychotic drug, Olanzapine, and said that he should continue to take Citalopram once a day. The RMN was present during the interview and she was concerned about the increased distress the man was experiencing due to the voices he could hear. He said that the voices were telling him to kill himself. After the interview, the RMN spoke to the lead RMN to express her additional concerns.

54. The duty ACCT assessor said that the ACCT assessment was completed after the man saw the duty doctor. She described the man as fine during the review, and said that he spoke up, listened and understood what staff had to say. He confirmed her account of what had been said during their earlier interview and they went on to discuss the care map. The care map said that the man would be referred to a psychiatrist and an alcohol self help group. The level of observations was increased to intermittent and he was to be seen that day by the prison's duty doctor. No reference was made to where the man should be located. The next review was scheduled for 15 January.

55. Although the ACCT review did not consider the man's location or decide that he should move to a safer cell, the HCO said that this was arranged and he moved to MY10, which is one of the safer cells on Y landing. The first entry on the Intermittent Observation sheet at 11.25am states that by this time the man had moved to the safer cell.

56. The duty ACCT assessor said that as she was not responsible for implementing any of the actions in the care map, she did not expect to see the man again. The review form states that the HCO was to be the man's case manager, but he said that usually a nurse would carry out that role. The HCO was not responsible for any of the actions decided at the review, and neither did he carry out any of the observations that day. He had no further contact with the man.

57. Four of the prisoners in healthcare at the time of the man's admission were interviewed, two of whom had held the responsibilities of cleaners and Listeners in the Healthcare Centre. All four men described the man as quiet and withdrawn, speaking only in monosyllables. Even when he was collecting his meals from the servery, one prisoner said that he used gesture rather than speech to indicate his choice. Although one Listener said he was not told when the man harmed himself, and another said that there was little support for prisoners after his death, a third prisoner said that staff were helpful and the Samaritans were excellent. They also made general comments about what they regarded as a high number of inpatients on ACCT monitoring in the inpatient unit, and the demands this places on staff.

2 January

58. The RMN was on duty again on 2 January. After completing the doctor's round, she made a number of telephone calls to community health services to try to locate the man's previous medical records. She sent a fax to the health authority to give his consent to sharing the information. The RMN also referred the man to the prison's MHIR team, as she thought that their support would help him.

59. The RMN did not participate in the intermittent observations, which were carried out by other staff, and there were no more signs of disturbed behaviour. A nurse was responsible for some of the observations during the afternoon and described the man's mood as low. He remembered that he was not very talkative and only recalled him speaking to ask for a light for a cigarette. He did not remember whether the man talked to other prisoners or other staff, even when he was waiting to collect his evening meal.

60. An officer was on duty that night with two nurses. Nurse A is a general nurse with many years experience working in the Healthcare Centre; Nurse B is a psychiatric nurse who had worked in the Centre for the previous four months. There were 17 prisoners on ACCT documents of whom three, including the man at the centre of this report, were to be observed intermittently. Because it was a Bank Holiday, the nurses had no administrative tasks which meant that all three members of staff were based in the inpatients wing and were available to share the observations.

61. On his fourth check at 7.25pm, the officer said that he saw the man at the hatch and thought that he must want some contact. He engaged him in conversation and the man told him about the voices he was hearing. During the conversation, the man's head moved to the right so that the officer could see into the cell. He saw that there was blood all over the man's chest and arms. He asked what he had done, to which the man replied "nothing". The officer immediately went to the office, a few yards away from the cell, and spoke to the lead RMN (who was about to go off duty) to tell him what had happened. They went to the cell where they saw that the man was standing upright and was able to talk to them.

62. As the prison was in patrol state and the man's injuries did not appear life threatening, neither the officer nor the lead RMN was authorised to enter the cell without permission. The lead RMN used his radio to contact the orderly officer, a Principal Officer (PO), to ask for permission to enter the cell. The orderly officer refused to allow them immediate access as the man's condition was not described as life threatening, and immediately made his way to the Healthcare Centre to make his own assessment. He arrived within five minutes.

63. Whilst waiting for the orderly officer, the officer collected some rubber gloves and returned to the cell door. He asked the man what he had used to cut himself and was told that it was a blade, which he pointed to on a shelf. He told the man to pass the blade, which came from a safety razor, and the

officer wrapped it in the gloves and disposed of it in the sharps bin in the office.

64. When the orderly officer arrived, he spoke to the lead RMN and the officer, saw the man for himself, and gave permission for the cell to be unlocked. The orderly officer remained in attendance, and described his role as ensuring that the prison's security was maintained. He said that he did not take part in the decisions about the man as he thought that the lead RMN knew him better. The orderly officer said that, had the lead RMN reported any cause for concern about the man's state of mind, he would have immediately called an ACCT review. It was the orderly officer's view that nothing more than first aid treatment was required. He did not speak to the man, but was aware that the others were doing so.

65. The man was taken along the corridor to the treatment room. He was found to have cut his left forearm between his wrist and elbow. His injury was cleaned and dressed by Nurse A in the lead RMN's presence. Nurse A described the man as quiet but biddable whilst she treated his arm. The injury was described as a minor one-inch laceration to his left arm. Nurse A said that she was with the man for about six minutes, but took no part in the conversations with him or the decisions about his care. The officer went to collect fresh clothing and prepare the bed in another cell.

66. Whilst the man was being treated, he told the lead RMN that he had cut himself with the blade because the voices in his head had told him to do so. After the wound was treated, Nurse A left and the lead RMN remained behind on his own to speak to his patient. The man said that the medication was not helping and he wanted to see the doctor again. The lead RMN thought that he was talking normally and that he was relaxed. The man told him that he had cut himself to relieve the pressure he felt and that he would not do it again. The lead RMN agreed to his request to see the doctor again and told him that he would put him on the list for the following day, which he said seemed to give reassurance. They shook hands at the end of the conversation, and the lead RMN was confident that he would not come to any more harm as he thought that the man's stress levels were relieved by the act of cutting himself. He did not consider arranging for the ACCT review to be brought forward, and did not think that the level of observations needed to be increased.

67. After the lead RMN talked to the man, he and the orderly officer returned him to the cells. The officer strip searched the man to make sure that no other weapons were concealed. Due to the amount of blood in MY10, they decided that it needed industrial cleaning before it could be used again. Nurse A said that the cell was covered in blood with so much on the bed that it was like a puddle. The only other available cell was MY7, which is the gated cell opposite to the office. The orderly officer was unaware that this was not a safer cell, but said that he deferred to the lead RMN regarding arrangements for the man as he thought that he knew him better.

68. The lead RMN said that the man was placed in MY7, but the protocol for its use was not implemented, meaning that he was not placed on a constant watch. The gate was in place, rather than the door, and the lead RMN thought it appropriate that the level of observations remain intermittent. He was aware that all three night staff would be in inpatients and would be in or around the office which was opposite to the gated cell. The clinical reviewer has confirmed that, although the level of observations remained intermittent, in practice they were more frequent throughout the night. The gate was in place and the man was fully visible to staff.

69. The lead RMN gave the man a drink and switched the television on, before going off duty for the night. He told the night staff that, if the man deteriorated further, the level of observations should be increased to constant. The man was scheduled to see the psychiatrist the next day, this being the routine for all new psychiatric inpatients.

70. A second PO took over from the orderly officer who told her about the events earlier in the evening when the man cut his arm, and that he had been relocated to another cell. The second PO telephoned the Healthcare Centre and spoke to the officer to satisfy herself with the arrangements. She visited the inpatient unit twice during her shift and saw the man in the gated cell with the gate in place. She realised that he had moved from a safer cell to a cell without those safeguards, but said that she was satisfied with the arrangement as the new cell was opposite the office and so was better supervised. The second PO was confident in the officer as he was an experienced and diligent officer, and she did not think that additional resources were necessary. The second PO monitored the records to satisfy herself that the observations were being carried out as required.

71. The officer said that, although the official level of observations was intermittent, in fact the staff watched him constantly. Nurse A's recollection was that she had no more contact with the man during the rest of the night. The man settled quickly and slept throughout the night until about 6.10am when he was woken for his medication.

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72. The nurse present for the man's First Night Induction returned to duty the next morning and was responsible for some of the observations. He said that he did not remember the handover meeting, but said that, by the time he took over, the door to MY7 was in place and so he observed the man through the flap in the cell door. He originally thought that it had been a constant watch, but then acknowledged that it must have been intermittent, as the intermittent log was used as a record. He described the man as sullen, and said that he did not talk to either prisoners or staff. The unit's cleaner knocked on cell doors to request prisoners' meal choices, speaking to the man at about 8.20am. The man refused to choose a meal, saying "there's no point".

73. The RMN was also on duty again, arriving at the wing at about 9.30am when she saw the man in the gated cell for the first time. She had been occupied

with other duties when the morning handover took place, and so this was the first time that she became aware of the deliberate self-harm the previous evening when the man cut himself. He told her that he was okay, and she saw him again later as one of her duties was to accompany the doctor's round of all the inpatients.

74. The doctor who saw the man on his first night induction was again the locum doctor on duty. When the RMN asked the man to remove the dressing from his arm she saw that his injury was a small cut; at the time, she did not know about the amount of blood caused by the injury. She said that the man asked for his medication to be changed again, because he was still hearing voices. The doctor informed the clinical reviewer that it was hard to engage the man in conversation, and that he made little eye contact. The doctor was satisfied that the man's wound did not require any further attention, and he knew that the man had a routine appointment with the prison's psychiatrist later in the day.

75. The man refused lunch when it was offered to him at 12.15pm. At 2.55pm, the nurse said the man asked for some hot water and then for a toothbrush and towel. Later in the afternoon, he watched the television.

76. At 3.15pm, the man had a half hour interview with a psychiatrist employed by the Manchester Mental Health and Social Care Trust who works full time at the prison. He assesses all the psychiatric patients who are admitted as inpatients. The psychiatrist remembered the man from his previous prison sentence, and was aware of the treatment he received from community and hospital psychiatric services even though he did not have the records with him. He did have the ACCT records with him and made a brief entry there as well as a full entry in the man's continuous medical record.

77. This was the man's Initial Psychiatric Assessment and the psychiatrist assessed him as emotionally unstable, with a personality disorder and self harm tendencies. He described the man as down, anxious, restless and worried, but did not consider that he was depressed. The man asked for his medication to be increased as he said that the present dose was ineffective and, without an increase, he would hang himself. In the psychiatrist's experience, suicidal patients did not ask for help and so he considered that it was positive that the man asked for his medication to be changed.

78. The psychiatrist considered that the man's main problem was the auditory hallucinations (he said that the voices were telling him to kill himself and that he had taken an overdose previously whilst in hospital). The psychiatrist was aware that the man had harmed himself the previous day by cutting his arm. He said that such behaviour is often displayed as an accumulation of anxiety and anger, as a cry for help, and that often people feel happier afterwards.

79. The psychiatrist made a number of decisions about the man's care. He decided that the clinical records from his previous stay in HMP Manchester should be located, and the hospital where the man had been treated in the community should be contacted. He also decided to increase both his anti-

depressant and anti-psychotic medications. He increased the prescription of Citalopram to 70 milligrams daily and prescribed Olanzapine to stabilise his mood. As the man had already received the daily dose of Citalopram, the new dose was not administered, but he did receive the Olanzapine in the evening. Although the clinical reviewer makes no recommendations, it would have been good practice for the difference between the old and the new doses to be administered straightaway. The psychiatrist said that he would have expected the altered dose to have had an effect on his patient's mental health within one or two days.

80. The psychiatrist re-assessed the man's CSRA and considered him suitable for either a single or shared cell, but made no reference to whether he should be in a safer cell. In interview, the psychiatrist confirmed that he knew the man was in the gated cell, which was not a safer cell, and that the door was in place rather than the perspex gate. He said that no safer cells were available. Finally, the psychiatrist recommended that the intermittent observations continue and that a constant watch was not required.

81. The man returned to MY7 and at 6.05pm he collected his dinner which he ate in his cell. He declined to join in the association activities at 6.55pm. The officer who had witnessed the past evening's events returned to duty at 8.30pm. Because of what had happened, he was interested to find out how the man was and went to speak to him. The cell door was in place, rather than the gate, and observations and conversations were through the panel in the cell door.

82. The nurses on duty that night were again Nurses A and B. As clinics were scheduled for the following day, the nurses did have administrative tasks to carry out during the night. Nurse B was responsible for the inpatients and Nurse A held the radio for Hotel 1, which meant that she took care of the administrative tasks and any emergency calls from the rest of the prison. They came on duty at about 8.30pm and were told that the man was in the gated cell, which was closed as he had promised not to harm himself, and the intermittent watches were to continue.

83. The man told the officer he had seen the doctor, but was still hearing voices. They had several conversations in the course of the evening and the officer said that he had thought the man was better than the previous evening - less agitated and more settled. Although they had no lengthy conversations, the man did not just respond when he was spoken to, but called out to ask for what he wanted. He answered questions and gave the officer no indication that he was upset. At 8.35pm, he asked for a toothbrush and toothpaste, and later asked for the television to be altered. The officer provided hot water for a drink and the man also had a cigarette. During the evening, the man watched television and read several newspapers that the officer found for him. At 11.10pm, the man asked the officer for the light in his cell to be switched off for the night.

84. Nurse B said that she gave out medication to the inpatients and remembered that the man asked for his to be administered earlier than usual. The

medication administration records state that the man received his drugs at the normal time, and do not indicate whether his request was granted. Nurse B also carried out some of the observations of patients on ACCT. She carried the radio with the call sign Alpha Ten. When her tasks were complete and most patients were in bed, Nurse B went downstairs to the ground floor offices to assist Nurse A, but worked in a different room from her.

85. The officer checked the man again at approximately 11.25pm, when he saw him lying on his bed. The next observation was at 11.40pm. When the officer looked through the panel in the door, he saw the man hanging from a torn bed sheet tied to the window bars. He was facing the wall in a kneeling position, with his feet suspended from the floor and his head below the height of the window ledge. The nursing staff recall that he was wearing a T shirt, but were not sure what he was wearing on his bottom half.

86. The officer immediately shouted to the man through the panel in the door but received no reply. He attempted to use his radio to summon healthcare assistance, but discovered that the battery was flat. Due to the seriousness of the situation, the officer broke the seal on his sealed pouch, opened the door and went in alone. He used his torso to take the man's weight and lift him to reduce the pressure being exerted by the ligature. The officer then used the ligature scissors in his pouch to cut the bed sheet and, still single-handedly, placed the man on his back on the floor.

87. The officer did not have an up to date first aid qualification, but had undertaken emergency aid training when he joined the Healthcare Centre 18 months previously. He said that the man's body was warm but he was not breathing and he decided that the priority was to get some air into him. He took a towel from the bed in the cell and placed it under the man's shoulders in order that they were raised. He used the sheet to wipe the man's face, before administering two breaths and a number of chest compressions. The officer said that this was difficult because the man had a beard, but he thought that the breaths were successful.

88. The officer then left the cell momentarily to return to the office and get a new battery for his radio. He swapped the battery and immediately put out a call for Hotel 1 (healthcare) to attend at the inpatient unit. He did not use the telephone as he said that he could not be sure which room the nurses were working in or which number to use. The officer returned to the cell and resumed cardio pulmonary resuscitation (CPR) on the man, alternating breaths and chest compressions.

89. The officer was then joined by a second officer, who was working in the juvenile unit adjacent to the inpatient unit and had heard the radio call. The second officer had heard an earlier call and so was aware that at least one of the nurses would have been called away from the unit. He also knew that the second nurse might be working in the ground floor offices and realised that the first officer was likely to be on his own. When he got to MY7, he found that the first officer had already managed to lay the man on the floor. Together they used the heart start technique to try to revive him.

90. Between two and three minutes later, Nurses A and B arrived at cell MY7, having heard the radio call and made their way upstairs. They did not know which cell to go to, so made their way towards the office where they saw the officers in the gated cell. They saw the man on the floor with the first officer attempting CPR. Nurse B said that she could not see the man's face, but could see that he was pale and felt that he was still warm. She was told that he had hanged himself. Nurse A checked the man's pulse but could not detect one.

91. The nurses joined the officers and all four continued to take turns to administer CPR. Nurse A said that they did not attempt to insert an airway, and this was done later by the paramedics. The staff described administering CPR as physically hard work. The second officer did not think that the man responded, but nevertheless they continued their efforts until the paramedics arrived.

92. The PO on duty the previous night was on duty again as the night orderly officer, and she and an SO heard the radio call and went to the Healthcare Centre. Whilst on their way, the PO put a call out over the radio for the control room to contact the emergency services. She also deployed an officer from another wing to come to the unit to check the other prisoners' welfare. The SO went to collect the emergency bag from the ground floor printing room and Nurse A got out the emergency equipment.

93. For the next 15 minutes the officer and the second officer, and Nurses A and B worked in pairs to administer CPR until three paramedics arrived at around midnight. The paramedics instructed the prison staff to continue giving CPR whilst they organised their own equipment. The paramedics then assumed responsibility for the man's treatment, with the continued assistance of Nurse B.

94. At 12.20am, the man left the prison by ambulance and was taken to North Manchester General Hospital. In accordance with general prison policy, two prison officers accompanied him to carry out bedwatch duties. Due to the seriousness of the man's condition, a risk assessment was not carried out and restraints, such as handcuffs, were not used.

After the man left the prison

95. The ambulance arrived at North Manchester General Hospital at 12.30am. The man was immediately conveyed to the Accident and Emergency Department where hospital staff attempted to stabilise his condition. At 4.00am, he was operated on in an attempt to improve his chest ventilation before being transferred from the operating theatre to the recovery room at 9.00am.

96. After the man left the prison, the PO led a hot de-brief meeting for the staff who had assisted him, and arranged cover for healthcare staff so that they could be relieved of their duties for a couple of hours. She asked the extra

officer to check that the prisoners on ACCT were alright. She also briefed the Duty Governor about events, and together they spoke to staff to check that they were fit to continue working.

97. The next morning, the Acting Head of the Healthcare Centre checked the medical records of a previous sentence as the man had not provided contact details for his next of kin. She discovered his mother's address and the Safer Custody manager said that the details were verified by Greater Manchester Probation Area.

98. A female SO was asked to assess the man's situation and conduct the security risk assessment. She obtained relevant information from the man's prison records, familiarised herself with the layout of the ward and healthcare staff briefed her about the man's medical condition. Because he was in a critical condition, the man was in the intensive care ward which contains up to six beds rather than in a side room on his own. The SO reported the information to the governing Governor, who gave permission for the man to remain unrestrained by handcuffs. The governing Governor confirmed the usual security arrangements of two bedwatch officers, and said that they should be stationed about 15 yards away from the bedside at the door of the ward. It is usual practice at HMP Manchester for two officers to carry out bedwatch duties and for them to wear their uniforms. No handcuffs or other restraints were required and the governing Governor noted that these arrangements should be reviewed if the man's health improved. He also permitted visits by the man's family.

99. The SO arranged to visit the hospital and take the completed risk assessment with her. She discovered that a further PO, the prison's Death in Custody Liaison officer, the Acting Head of Healthcare, and a member of the chaplaincy team were about to visit the man's mother to tell her of his condition. The SO joined them in the car and they all went to the mother's home, but found no-one present.

100. The SO went on to the hospital, arriving at approximately 11.20am. She checked that the two bedwatch officers were in the correct location and had all the necessary equipment and information. The man's condition was such that his bed was screened with a doctor sitting at the foot of the bed.

101. During the afternoon, a PO accompanied the Acting Head of Healtcare to the man's mother's home and were able to tell her what had happened. They offered to take her to the hospital, but she declined. She waited for another family member to return from work so they could go together.

102. Officer A was one of several officers who carried out the bed watch duties and who recorded their checks in the bedwatch log. He was on duty during the afternoon on 4 January together with Officer B. Because Officer A had more years' experience, he took charge of the arrangements during their shift.

103. When Officer A came on duty, the man was in a recovery room outside one of the hospital operating theatres, which is where patients wait before and after

their operations and so are in various degrees of consciousness. He was told that the man's family had not yet been contacted. The management check for the day had already taken place. At about 4.00pm, the man was moved to the intensive care unit and the officers accompanied him and sat about 15 yards from his bed. This ward has about six patients, with relatives sitting by the bedsides and hospital staff coming and going. There is a telephone in the middle of the ward.

104. At 6.15pm, Officer A said that he was in the unit, finishing a routine telephone call to the prison, when Officer B told him that three women had arrived unexpectedly. Officer A said that their arrival took the officers by surprise, and he deduced that they were the man's mother and sisters. He decided that they did not present a security risk, and said that they were upset. The women went to the man's bedside. After about 45 minutes, Officer A said that he introduced himself to the man's mother and explained that he needed to get identification from her. He said that she realised that it was his job to ask these questions, and she went on to ask him how the man had been allowed to hang himself.

105. Subsequently, Officer A telephoned the prison and spoke to an SO see what visits were allowed. The enquiry was passed to the duty governor, who rang back and spoke to Officer B to tell him that the family could remain throughout the night.

106. Despite the efforts of the hospital staff, the man's condition failed to improve and, at 5.25pm on 5 January, his family gave permission for the life support machine to be switched off. The man died at 6.10pm. The preliminary death certificate stated that death was due to pneumonia, which is a common side effect of intubation and is likely to have developed in hospital.

107. Arrangements were subsequently made for the man's family to come to the prison and visit his cell. A governor was present during the two hour long visit, together with the Acting Head of Healthcare and the PO who had accompanied her to the mother's house. The governor said that they talked about general issues around suicide, as well as specific issues relating to the man. He described the conversation as initially hostile, but said that it changed and ended on a more friendly note. He is aware that the man's family have expressed concerns about things which were said to them, but says that no rudeness was intended and their concerns are regretted. The man's family were also given the opportunity to visit the Healthcare Centre and speak to staff who responded when he was discovered. The Acting Head of Healthcare and the PO who had accompanied her to the mother's house attended the man's funeral.

Issues considered during the investigation

Treatment of the man's mental illness

108. Prison and healthcare staff in reception quickly realised that the man suffered from psychiatric illness and required medication which he said he had been without for the previous five days. Using the information the man provided, he was first prescribed anti-depressants and subsequently anti-psychotic medication. The clinical reviewer notes that he did not go to the treatment room to receive his medication for five days after the prescription was written. She comments that the medication should have been available, and that it is not acceptable that prisoners can miss their medication without any action being taken. The reviewer states that, since the man's death, new prisoners are told how to obtain their medication and this is reinforced by wing staff. Follow-up action is now taken when any prisoner fails to collect their medication on three consecutive days.

109. The man was seen by doctors on three occasions, by the prison's psychiatrist, and was also referred to the Mental Health In Reach team. When he was on the wing and his symptoms worsened, wing staff quickly realised and took appropriate steps to arrange a clinical assessment.

110. The man was admitted as an inpatient to the Healthcare Centre. The inpatient unit regularly cares for prisoners suffering from psychiatric illness, and the man was not unusual. There are many more such prisoners located in the wings. Manchester Mental Health and Social Care Trust and the prison are already working together to develop their provision and the Trust is resourcing innovative services for psychiatric patients on the wings, such as a day centre and therapeutic groups. Staff from both the Trust and the prison meet twice weekly to discuss patients and common issues, and all concerned describe good working relationships.

111. As far as I can ascertain, and consistent with the opinion of the clinical reviewer, it appears that all possible efforts were made to treat the man's mental illness. I particularly note that this was achieved during the Christmas and New Year holidays when staff were on holiday and the inpatient unit was busy.

112. However, my investigators' impression of the regime and environment in the inpatient unit is less positive and little seems to be available for prisoners like this man. The cells are clean and freshly painted, but provide a bleak environment and the gated cell is particularly bare. Specialist psychiatric nurses are often occupied on duties which take them away from patients, and it is not evident that all work consistently to the same best practice. The regime offers little, other than a few education places, to interest and occupy the patients. The man spent most of his time on his own with little to provide comfort or diversion.

113. I recognise the huge needs of the prison's population and the efforts already being made to improve the quality of care for mentally ill prisoners, and so

make no formal recommendations. However, I urge the Trust and the prison to place inpatient provision higher up their agenda, and work together to improve those facilities as well as those on the wings.

Access to previous records

114. Steps were taken to retrieve the records from the man's previous period in custody, and to obtain those from his hospital admissions, but I have been unable to ascertain when they arrived. It is likely that they were not available when the man was interviewed by the prison psychiatrist on 3 January. Although they would have been helpful, I consider that the vital decision about maintaining the intermittent watch was verified by the prison psychiatrist, who had a full recollection of treating the man previously and was not dependent on earlier records for relevant information. I do not think that the absence of the man's records had any effect on the decisions about his care.

115. However, I am pleased to note the clinical reviewer's comment that, since the man's death, a procedure has been put in place whereby reception staff identify whether there are previous records and take steps to obtain them.

Implementation of ACCT

116. Many aspects of the implementation of ACCT were commendable. It was decided promptly that the man should be placed on ACCT when he arrived at the Healthcare Centre, a full initial assessment was carried out, and appropriate objectives were set. The observations took place as directed and were checked as required by the prison's managers. Records - including the observation records - were comprehensive, orderly and clear, and actions took place when they were supposed to have done. Other than to protect medical confidentiality, the records were multi-disciplinary and, in particular, the psychiatrist ensured that he recorded his decisions in the history sheets as well as in the medical records.

117. The ACCT review took place as required, led by a trained reviewer and attended by the man and healthcare staff. I suggest that the attendance of the healthcare officer who had not previously met the man did not contribute as much as his named nurse, the RMN, could have done. Nevertheless, the review generally took appropriate decisions and the man appears to have engaged with the process.

118. However, the review did not give any thought to the man's location, and the decision to move him to a safer cell was taken separately. In my view, all ACCT review panels should be aware of the location of a prisoner, and the review should state where they should be located. Furthermore, I recommend that all changes of location for prisoners on ACCT should lead to the review panel being reconvened.

119. I am also concerned that no thought appears to have been given to reconvening the review after the man harmed himself, and I recommend that all such injuries are followed up by a further review. In this man's case, the

follow up ACCT review was to take place on 15 January, and neither the self harm incident nor the move out of a safer cell resulted in the date being brought forward.

Staff observations

120. The man's family have said they were informed that staff were missing from the inpatient unit and neglected their duties, for example, by failing to notice that a cell had been flooded. From interviews with the staff responsible for observing the man, from the records, and from interviews with the senior managers responsible for monitoring staff conduct, I am satisfied that all observations were carried out as required and as agreed in the ACCT reviews.

121. I have also asked the prison to investigate the family's allegations and been informed by the Acting Head of Healthcare that there are no records of a flood occurring around 3 January. She also says she is satisfied by the numerous entries in the records that staff were carrying out their duties as required.

Self harm incident

122. The man used a safety razor to cut his arm on 3 January. I am informed that he had secreted the razor when he was admitted from the wing, and razors are only available to inpatients when they are shaving and are supervised by staff. I am surprised that he was able to hide the blade and was not searched when moving from the wing to the Healthcare Centre.

123. Although the man remained safe for more than 24 hours after cutting his arm, the response that evening could have been improved. In interviews with the staff who responded, each seemed to have thought that another was responsible. It did not appear that decision-making was clarified or co-ordinated:
- The ACCT arrangements did not appear to be evaluated, except by the lead RMN, and the others did not participate in the process.
- No arrangements were made to re-schedule the ACCT review.
- Of the four staff present, at least two confirmed that they did not actually speak to the man and they did not appear to have made their own assessment of his mental wellbeing.
- A senior member of the healthcare team and the Oscar 1 were present but it was not clear that they understood who had ultimate responsibility for the decision to move the man to another cell.
- The first Oscar 1 was unaware that the new cell was not a safer cell.

However, I do not consider that these deficiencies led to the man taking his life the following day. The critical thing is that the arrangements for his care were subsequently confirmed by the psychiatrist.

Allocation of cells

124. When the man was admitted to the Healthcare Centre, he was located in an ordinary cell, X4, and placed on ACCT. The following day, the ACCT review

took place but there is no indication that his cell was discussed and no discussion took place about whether the man should move to a safer cell. Nevertheless, after the review the man was moved to MY10, a safer cell, although no record was made to say that he should remain in these conditions.

125. Whilst in the safer cell, the man managed to cut himself and lost a lot of blood. I am satisfied that he could not remain in MY10, which was soiled with blood and needed more cleaning than could safely be carried out by prison staff and required the outside contractors. The only available cell was the gated cell, MY7, which is not a safer cell and is generally used for prisoners who are watched constantly. All the cells in the Healthcare Centre are part of the prison's total number of beds, and so have to be occupied irrespective of a prisoner's individual circumstances.

126. The decision to place the man in the gated cell was made by the lead psychiatric nurse together with the principal officer on duty at the time, and they also decided that he should continue to be observed intermittently. Their decisions were confirmed later that night by the next principal officer on duty and, crucially, the following afternoon by the prison's consultant psychiatrist who had met the man when he was in prison before. The psychiatrist was fully aware of the man's location and the level of monitoring, and did not change either.

127. Although I understand the restrictions on available cells, and respect the decisions of all the staff, including the psychiatrist, I share the concerns of the man's family. Essentially the outcome of the man harming himself was that he moved from a safer cell, where he could not hang himself, to one where he could attach a ligature. It is difficult to avoid the conclusions that the level of monitoring should have been increased to constant and the ACCT review should have been brought forward.

128. The clinical reviewer shares these concerns and recommends that the gated cell is only used for prisoners requiring, and having, constant observations.

Bedwatch arrangements

129. The man's family reported that bedwatch staff were rude to them. My investigators have interviewed one of the bedwatch officers and the manager responsible for implementing the arrangements.

130. Although I make no recommendations, the Governor may wish to consider whether, in similar circumstances when a prisoner is in a shared ward, the presence of bedwatch officers can be more discreet. They were in uniform, in full view of other patients and their relatives and used the ward telephone to liaise with the prison. The officers were surprised when the man's family arrived unexpectedly. They were untrained to deal with family situations and on their own without management support. As far as I can tell, the bedwatch arrangements for the man were the same as for any other Manchester prisoner. I am satisfied that the officers did the best they could in a difficult

situation, but the Governor may wish to give further thought to the bedwatch arrangements in circumstances such as these.

Conclusion

131. The man upon whom this report focuses had a long history of serious mental illness and had harmed himself at least once before. He arrived at HMP Manchester on 16 December. Eighteen days later, he apparently hanged himself from a ligature attached to the window bars of the gated cell in the prison's Healthcare Centre.

132. Wing staff, not knowing his medical history, correctly recognised the man's mental health problems. These were confirmed by a psychiatric nurse and he was admitted as an inpatient and placed on ACCT. Those at the initial ACCT review were sufficiently concerned to increase the level of observations and he was moved to a safer cell.

133. The next day the man cut his arm and, after first aid was administered, he was moved to a clean cell but one which had ligature points. The level of observations remained the same. He was assessed by the psychiatrist who confirmed these arrangements. Despite extensive safer custody and psychiatric support, the man continued to complain that he heard voices telling him to kill himself. However, while my investigators formed a less than favourable impression of the regime and environment in the inpatient unit, I am satisfied that in the next 24 hours there was no indication that his risk of suicide or self harm had increased. Nevertheless, between two routine observations, the man seems to have managed to attach a ligature to the window bars and hang himself. He died in hospital two days later.

134. I find it difficult to accept that a man who was subject to ACCT, and who had just harmed himself, could be moved from a safer cell to an unsafe one yet be monitored at the same level of observations. Although it is with the power of hindsight, had the man remained in a safer cell, or if the level of observations had been increased, the events of 3 January would almost certainly not have occurred as they did.

Recommendations

National

1 I recommend that the ACCT guidance is amended to require that reviews are automatically convened after an incident when a prisoner harms him or herself and if they are to be moved from a safer cell.

Local

2 I recommend that all prisoners are searched when moving from the wings to the Healthcare Centre.

3 I recommend that the Governor and the Head of Healthcare review the arrangements for ACCT reviews and ensure that the most appropriate staff attend.

4 I recommend that the gated cell is not used for prisoners deemed to be at risk of suicide or self harm unless on constant observation.

Good Practice

5 I recommend that the Governor commend the officer on duty that night for his actions when he discovered the man hanging. He went into the cell alone and commenced cardio pulmonary resuscitation. Without his efforts, it is unlikely that the man would have lived long enough for hospital staff to operate and attempt to save his life.