Investigation into the circumstances surrounding the death of a man at HMP Hull in March 2007

Report by the Prisons and Probation Ombudsman for England and Wales

December 2007

This is a report into the circumstances of the death of a man at HMP Hull, in March 2007. He was found in his cell early on Sunday morning when a staff member noticed that the observation hatch on his cell had been blocked. Despite staff attempts at cardio pulmonary resuscitation and the attendance of paramedics, he was pronounced dead at 3.08am. He was 27 years old.

I offer my sincere sympathy and condolences to the man's family and friends for their loss.

The investigation was carried out on my behalf by two of my colleagues. A clinical review of the man's healthcare at HMP Hull was undertaken by Hull Teaching Primary Care Trust. I am grateful for the comprehensive and timely report.

I would like to thank the Governor of Hull and his staff for their co-operation and assistance with this investigation. Particular thanks go to the principal officer who was a most efficient liaison officer, for his help throughout the investigation process.

The man had been at HMP Hull for just a few days. He had been arrested following the alleged breach of a restraining order, but was adamant that he was not guilty of the offence. The man accordingly felt aggrieved and this sense of injustice was a constant theme in his conversations over the phone to family and friends. In a note, he wrote the phrase, "I'm innocent" and then outlined the words with dotted lines. In another he said that he could not take any more. It seems that the idea of spending any further time in prison in these circumstances was something he could not endure.

Emma Bradley
Prisons and Probation Deputy Ombudsman **December 2007**

CONTENTS

Summary	4
The Investigation process	6
HMP Hull	7
Key findings	8
Issues	15
Recommendations	21

Annexes

1. Documents considered during the investigation
2. Clinical Review
3. ACCT from August 2006
4. Instruction sheet for ACCT observations in use at Hull
5. Transcripts of interviews

SUMMARY

The man was born on in 1979 and died in the early hours of a Sunday morning in March 2007, at HMP Hull. He grew up in Hull and, as an adult, lived and worked in the city. He was separated from his wife with whom he had one child.

In June 2006, the man's wife obtained a restraining order against him. The following month he was sentenced to 12 months imprisonment for driving offences. He initially went to Hull, but in August was told he was being transferred to a more distant prison. He then took an overdose and told staff that he did not know what else to do. Staff opened an ACCT plan to give him additional support through the crisis. An ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give him the support he needs to help him through a period of crisis. They also arranged for his transfer to be changed to HMP Everthorpe, which was much closer to Hull. The following day, the man moved to Everthorpe.

In November, the man's relationship with his wife broke down and he again took an overdose, for which he was treated in the healthcare centre. Staff opened a new ACCT, which remained in place until 26 November. In January 2007, the man was released from prison.

In early March, the man was arrested by the police and charged with breaching the restraining order. He was received into Hull later the day and was interviewed by a number of staff during the reception process. They noted his high daily consumption of alcohol and previous self-harm attempts, both inside and out of prison. However, none of them felt that the man was at risk of harming himself at that time.

The man was then allocated a shared cell in the induction wing. As a result of his charges, the man was subject to the restrictions imposed by the Protection of Harassment Act 1997, as laid out in Prison Service Order (PSO) 4400.

The following morning, the man was assessed by the doctor who prescribed an alcohol detoxification programme. The doctor was concerned at his low mood and his thoughts of suicide. She appropriately opened an ACCT plan, which remained in place for the rest of his time in Hull. When an ACCT assessor interviewed the man later that morning, the man said he was very angry at being in prison, because he was totally innocent of the charges. He was convinced that when he returned to court in a week's time, he would prove his innocence and be released. He was also very eager to contact his solicitor. However, in line with PSO 4400, he was not allowed to use the telephone until the numbers he had given were checked. PSO 4400 relates to prisoners convicted of, or charged with, offences under the Protection from Harassment Act 1997. It sets out a range of measures to prevent such prisoners from Harassment Act 1997, from continuing to harass their victims while in prison

On Friday afternoon, he was able to use the telephone and over the next 24 hours, he made a number of phone calls. Most of them related to his appearance in court the following week. The entries made in the ACCT plan show that the man spent most of Saturday afternoon sleeping or watching television.

At 2.34am on Sunday, staff entered the man's cell because the observation flap had been covered up and there was no response to their calls to clear it. The man was found suspended from the light fitting. Staff cut the ligature, laid the man on the floor and called for assistance. They then began cardio pulmonary resuscitation (CPR). The duty nurse attended and continued the resuscitation attempt. An ambulance and two paramedics arrived 15 minutes later. Sadly, none of the efforts made to resuscitate the man were successful and he was confirmed dead at 3.08am. The Governor and a family liaison officer visited the family at 6.40am to break the news of the man's death.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Hull on 14 March 2007, by two of my colleagues. Notices were issued informing staff and prisoners about the investigation and inviting anyone with information to come forward. All documents relating to the man were made available, including the records from his previous period of imprisonment. The investigators also met members of the Prison Officers' Association and Independent Monitoring Board (IMB).

2. In accordance with my Terms of Reference an independent clinical review of the man's health needs, whilst he was in custody at HMP Hull, commissioned from Hull Teaching Primary Care Trust (PCT). The review can be found, in full, at Annex 2.

3. One of my family liaison officers contacted the man's family. The family were concerned about a previous occasion when the man had harmed himself and whether there were records of what happened. My report deals with this issue in paragraphs 10 to 13.

HMP HULL

4. HMP Hull opened in 1870 and is now a Category B adult male and Young Offender local prison serving the courts in East and North Yorkshire and North Lincolnshire. There are nine residential units. The maximum number of prisoners that can be held is 1,071, and the certified normal accommodation is 812.

5. In March 2004, HM Chief Inspector of Prisons carried out an announced visit and reported that the prison was providing a largely safe and decent environment. Additionally, the prison was given a full Standards and Security Audit in 2004 and has been rated "good" in both areas.

6. Hull has implemented the Assessment, Care in Custody and Teamwork (ACCT) approach to helping and monitoring prisoners at risk of self-harm. The key aims of ACCT are to create a safe and caring environment, to identify prisoners' individual needs and to offer individualised care and support before, during and after a crisis.

7. Hull operates both the Insider and Listener scheme. The role of an Insider is to welcome newly arrived prisoners, highlight any concerns they may have, and to explain the processes they will encounter in the early days of custody. Listeners assist those prisoners who require additional support at any time during their period in custody.

8. PSO 4400 relates to prisoners convicted of, or charged with, offences under the Protection from Harassment Act 1997. It sets out a range of measures to prevent such prisoners from Harassment Act 1997, from continuing to harass their victims while in prison. Prisoners subject to PSO 4400/1 are prevented from making unauthorised contact with certain identified individuals. The restrictions of the Public Harassment Act 1997 means that the prison tries to balance security and good order with protection of the public and the prisoner's need to maintain family ties.

KEY FINDINGS

9. The man had some previous petty offences on record, mainly related to driving. The majority of these had been dealt with by way of driving bans and fines. However, after failing a community service order he served a short sentence between January and May 2001. The man's records did not contain a list of previous convictions, so it is not known whether that was his first time in prison.

10. A pre sentence report written by a probation officer, in 2006, details the man's excessive use of alcohol and his disturbed emotional state. She also recorded that the man had previously attempted suicide, in 2005, by taking an overdose of his grandfather's pills. The man said he saw his doctor after this attempt, but it is unclear if any diagnosis was made regarding depression or poor mental health. The man confirmed at the time that he had made no further attempts at self-harm or suicide.

11. In 2006, the man was sentenced to 12 months imprisonment for further driving offences and was taken to HMP Hull. Following usual procedures, a cell sharing risk assessment was completed. On the assessment form, staff recorded, "ACCT last time in prison. Family probs - now sorted". An Assessment, Care in Custody and Teamwork (ACCT) plan is a monitoring and assessment process, used to observe and support more closely those prisoners at risk of harming themselves. No further mention of this ACCT plan is made in the man's prison records.

12. The following month, the man was told that he was going to be transferred to another prison. He had applied to go to a nearby prison, but was allocated to one he felt was too far away. In August, he took an overdose of his prescribed medication, but was discovered by staff before any harm was done. The man told staff that he had taken the pills because the new prison was too far away for his wife to visit, given her poor state of health. The man was taken to the healthcare centre where he was examined by a doctor. Staff opened an ACCT plan and the man then returned to his cell on D wing. Staff monitored him during the night and in the morning he was interviewed and assessed by a member of staff. The man said that he had been "very low" the previous day and had not known what to do. Staff arranged for his transfer to be changed to HMP Everthorpe - a fifteen minute car journey from Hull. This resolved the issue and the ACCT plan was closed. The doctor then examined the man again and said that he was fit enough to be transferred. The next day, the man was taken to Everthorpe.

13. On 17 November, the man told staff that his relationship with his wife had broken down. Staff then opened another ACCT plan. The following day he took an overdose of 12 ibuprofen pills and eight paracetamol and was treated locally in the healthcare centre. The ACCT remained open until 26 November. The man was released in January 2007.

14. The man was arrested in early March 2007, charged with assaulting his wife and having contravened a court order imposed in June 2006. A risk assessment carried out by the police identified that the man was taking medication but no

record was made of what it was. Also noted was the fact that he had tried to harm himself in the past, having taken an overdose during a previous time in prison. The police also recorded that the man said he had been drinking all night.

15. A prisoner escort record (PER) accompanies every prisoner as they move between police custody, the courts and the prison system. It is used to highlight any immediate concerns staff may have about the prisoner in their care and pass that any relevant historical information to the next agency who might deal with them. The man's PER form highlighted self-harm, as well as drug and alcohol issues. He was remanded in custody for a week.

16. In Hull, the man gave his mother as his next of kin and supplied her contact details. He also said that he had previously spent a year in prison for a drink driving offence and had been released from HMP Everthorpe in January 2007. He then confirmed that he had been remanded for one week. The duty senior officer completed the harassment notification on the reception form as required by PSO 4400.

17. The man was then seen by an officer who completed the first section of the Cell Sharing Risk Assessment (CRSA). He indicated that he had seen the man's PER and the warrant information. He noted on the form that the man replied no when asked about drug or alcohol issues. In answer to the question 'is there any evidence of the prisoner being subject to previous suicide watch', the officer ticked the 'no' box. He then ticked the box that said the man was a low risk. In the space available to make any other comments, the officer wrote 'no concerns'.

18. However, the answers that the man had given the officer were different from the information on the PER form, especially in relation to alcohol use and previous self-harm attempts. The officer told my investigators that unless he has evidence to support what is recorded on the other documents he uses the information given by the prisoner to complete the CSRA. He explained that the CSRA and the PER are sent to the induction unit with the prisoner, so both are available to the induction wing staff.

19. The man then went to the first night centre on A wing. He was seen by a nurse who completed the health care section of the CSRA, section 3. She noted the man's history, as given on the PER form. She indicated that no concerns had been raised as part of her assessment, writing, 'no concerns at present'. The nurse then completed the man's First Reception Health Screen. She noted that the man had been remanded for one week, on a charge of harassment. Again, the man told her he had been in prison before, having been released from Everthorpe earlier that year. The man reported no concerns regarding his physical health and the nurse noted that he 'looks fit and well, good weight for height'.

20. When asked about substance misuse, the man disclosed that he drank about two pints of vodka a day, along with 15 cans of lager. He confirmed that he had last had a drink the day before. He also said he smoked cannabis daily. The nurse noted that although the man had admitted to a serious alcohol problem, he was

not suffering any withdrawal symptoms at that time. She then referred him to the substance misuse team to assess his alcohol dependency.

21. In the section covering mental health, the man said that, in the past, he had been prescribed Prozac and amiltriptyline for his mental health. He said that he had tried to self-harm both in prison and the community, the last time being at Everthope two months previously, where he had taken an overdose. The nurse's summary of the man read, 'low in mood due to current circumstances, states no thought of self-harm at present despite'. The man asked the nurse for some anti-depressants to help lift his mood. She said that she would refer him to the doctor the following morning and they could discuss it then.

22. The CSRA was then signed by an officer on the induction wing. He ticked the box which indicated that the man should be 'located as normal', meaning he was deemed suitable to share a cell. At interview, the induction officer explained that he went though all the prison paperwork and rules and regulations with the man. This included the A wing First Night Centre and the Induction Unit questionnaire. He also recorded that the man said he had been in prison before. When asked if he felt like harming himself, the man answered no and also said he had no other concerns. He also asked the man if he had any other concerns and the man answered 'no'. It is also recorded on this form that the man was issued with a £1 phone credit. It is regular practice to issue this on a prisoner's first night. It allows them to contact their friends and family to let them know where they are. However, the man was subject to the provisions of Prison Service Order 4400.

23. The man had been charged with harassment and checks were necessary before permission to use the phone was granted. He should therefore not have been issued with a phone credit at this time. When the reception officer spoke to my investigators, he explained that although he had signed the form to say this phone credit had been issued, in reality it had not been credited to his account and this was merely an administrative error. He also made a note in the man's wing file, saying that an initial induction briefing had been given to the man and he had raised no concerns. He noted that the £1 phone credit had not been issued because of the harassment charge, but a phone call had been made on the man's behalf.

24. We know from other documents that the man was not cleared to use the phone until two days later. We also know that a phone call was made to the number the man provided for his next of kin, to let them know where he was. The observation records for prisoners serving their first night in custody show that the man was checked every hour throughout that first night at Hull.

25. At 9.50 the next morning, the man was seen by the duty doctor. She noted in the man's medical record that he had been abusing alcohol. As part of the alcohol withdrawal assessment, she recorded that his hands were moist and he had a visible tremor. She prescribed a standard detoxification regime. She also wrote that he appeared 'depressed, very low and was thinking about suicide' and that he had attempted suicide last year while in prison. She then opened an ACCT document to ensure that the man would have the additional support that he needed.

26. After the doctor had registered her concern, the man was seen by the wing senior officer who drew up an immediate action plan. As part of this plan, he arranged for the man to remain in a double cell on A wing, but stipulated that he would be checked hourly by the staff. He suggested that the man should use the Listeners and Samaritan services. He also encouraged him to keep in touch with his friends and family by telephone. There does not appear to have been any recognition that the man had not yet been cleared to use the phone.

27. The senior officer then held an assessment interview. The man told him that he was struggling to cope with his withdrawal from alcohol. He said that he did not feel he should be in prison, as he had not committed the offence of which he had been accused. The man told the senior officer that in the past he had taken an overdose of painkillers, but had not attempted self-harm recently. He had done this as his marriage was breaking up and he had felt low. The man said, on these occasions, he had wanted to die. The senior officer noted that although the man was low, he was discussing his situation openly and making good eye contact. He said the man had described his situation as 'bleak' and added a lot would depend on his forthcoming court appearance.

28. The senior officer's summary of the interview reflected the man's upset at finding himself in prison. He said the man had a history of self-harm and had admitted that he did not know how he would cope if he was returned to prison after his court appearance. It was agreed that the observations and monitoring should continue. The senior officer also noted that the man said he was close to his mother and was expecting a visit from her that day. The man then said he was receiving medication to help him with his withdrawal from alcohol.

29. There are several entries in the man's ACCT record that day, in which staff detail the daily interactions and observations. Staff reported that he had taken all his meals, was talkative and, when asked, told staff he was fine. It was also recorded that he was chatting amiably to his cell mate. An entry at 7.30pm shows that an officer had telephoned the man's grandfather, who said he would arrange for the man's mother to visit.

30. The following day, the man's medical record shows that he was reviewed by a member of the substance misuse team. During the review, the man said that prior to coming into prison he had been drinking in excess of 50 units of alcohol a day. He had been doing so every day for the previous eight years, with the exception of his periods in custody. He also said that he had numerous overnight admissions to Accident and Emergency units due to collapsing in the street from excessive alcohol.

31. Again, the entries in the ACCT document showed him talking to staff, chatting with his cell mate and apparently fine. However, later that day one of the chaplaincy team noted in the record that he had spoken with the man for about 15 minutes. The chaplain said that he had been asked to see the man by a member of staff. Before he went to the cell, he spoke to an officer in the wing office. The officer told him that the man would probably ask for his help in making a telephone call, but that was not yet possible as he was subject to PSO

4400. When the chaplain spoke to the man, it was indeed the man's over-riding concern. He said that he urgently needed to contact his solicitor. The chaplain pointed out that it was about 4.30pm on a Friday afternoon so there would probably be nobody in the solicitor's office. The man just repeated that he needed to speak to his solicitor that day and it was not right that he could not. The chaplain wrote in the ACCT that the man was shaking and was very agitated. By this time, he had been cleared to use the telephone. However, the man had given only three numbers for checking. None of these were for his solicitor so, he could not call direct. The man's telephone records show that the first time he used the phone was on 9 March at 3.34pm. He dialled his mother's number, but received no reply.

32. At some point during the day, the man wrote a series of notes to his family saying that he was innocent and he could not take being in prison when he had not done anything. One note appeared to be a draft letter to his solicitor asking him to obtain information to help refute the charge against him. There is no evidence that he subsequently sent a letter based on this draft. The notes are all dated at the bottom, but there is no time on them. They were found in his cell, after his death.

33. The following day, at 8.30am, the man's cell was opened so he could collect his medication. An officer later wrote in the man's ongoing ACCT record that he spoke very quietly and appeared low in mood.

34. The man made three phone calls that morning. The first was to his mother and they talked for over six minutes, discussing his case. The record of the call shows that he was upset and angry. He told her that he was struggling to deal with things and had been put on 'a watch'. He said "I felt like doing myself in because of something I hadn't done". He repeated the phrase, "I shouldn't even be here!" a number of times. He also mentioned that he had not been able to make a phone call to his solicitor. She reassured him that she was in contact with his solicitor and would be in court to support him on the following Wednesday.

35. He then telephoned his cousin at 11.16am. His cousin was not home, so the man spoke briefly to his cousin's girlfriend. The man then redialled his mother's number and spoke to her for a further three minutes. He checked that his mother had arranged to visit him and again they spoke about his case. The man told his mother that he had been unable to call his solicitor because of the harassment allegation. His mother again reassured him that she had been in contact with his solicitors and was due to visit their office the following Tuesday, the day before the man was due back in court. The man mentioned that he had asked staff several times for a phone call to his solicitor during the previous two days. He said he was told to make a written application to see his solicitor.

36. The man was seen by several other staff members that day, who all recorded that at various times he was watching television, talking with his cell mate or sleeping. At 8.00pm, the man was checked by one of the OSGs, who wrote, 'He is sound tonight, he stated no problems'.

The night of the man's death

37. At 8.30pm, the officers on night shift came on duty and at 9.00pm the prison went into night patrol state. The night orderly officer (radio call sign Oscar1) was the most senior officer on duty in the prison. He was assisted by two officers whose call signs were Oscar 2 and Oscar 3. The wings were patrolled by Officer Support Grade (OSG) staff, as is usual. There was a duty governor on call.

38. During night patrol state, only Oscar 1 carries a full set of keys to unlock all gates and cells. Oscars 2 and 3 also have keys that allow them to move through the prison. Wing staff and nurses do not have access to keys allowing them free access around the prison and have to be escorted. Oscar 2 told my investigators that when he is Oscar 2, he usually carries a cell key and he did so on that night. The OSGs are each issued with a cell key in a sealed pouch for use in emergencies. The staff instructions are that during the night state, a cell may only be unlocked by a single member of staff where there is, or appears to be, immediate danger to life.

39. Two OSGs were responsible for patrolling and checking the prisoners. As part of the handover from the day staff, one did a roll check and made a note of the prisoners who had to be checked during the night, including those on ACCT plans. The man was to be checked once during every 60 minute period. (Such checks are 'at irregular intervals' rather than every hour, on the hour.) The other OSG carried out the checks up to 11.00pm and then the first took over. He told my investigators that when he checks a prisoner he opens the observation flap on the cell door and looks in. He does not move on until he is satisfied that the man he is checking is 'settled, content and okay'. When he checked the man at 1.00am, he was writing and appeared settled.

40. The next time the OSG went to check the man was about 2.30am. When he opened the observation flap he realised that contrary to prison rules, it had been covered from the inside. Therefore he could not see the man or his cellmate. The OSG shouted through the door for the men to uncover the flap but there was no reply. He kicked the door to attract their attention and called the man's name, again without reply. He then shouted to the cellmate, but still got no reaction. The OSG told my investigators that he thought the men were playing a game and were having a laugh at the staff. He told the men that unless the flap was uncovered he would put them on report. When there was still no reply, he went upstairs to get advice from Oscar 2.

41. Oscar 2 decided to accompany the OSG to the man's cell. When there was still no response from the men in the cell, Oscar 2 unlocked the door. As the staff entered the cell, the towel that had covered the flap fell to the floor. The officers then realised that the man was directly in front of them and was hanging from the light fitting. Oscar 2 immediately lifted the man up, while the OSG used his anti-ligature knife to try to cut the man down. When he was unable to do this, Oscar 2 took over. The OSG then summoned help over the radio by saying that there was a 'Code Blue' at the man's cell. This told everyone that it was a medical emergency that involved someone with breathing difficulties. Oscar 2 succeeded in releasing the sheet from the light fitting and the two officers lowered the man to

the floor. Oscar 2 began mouth-to-mouth resuscitation, while the OSG performed chest compressions. When the staff entered the cell, the cellmate was asleep in the top bunk, but he woke up as staff went to the man's aid.

42. When the OSG called the Code Blue, all staff who were carrying radios heard it. The OSG who was on duty in the communications room and he recorded the call as being made at 2.34am. Oscar 1 immediately went to A wing. On his way, he called Oscar 3 and told him to collect a nurse from the healthcare centre and escort her to the man's cell. When the duty nurse heard the call, she collected the emergency equipment bag and went to the gate at the entrance to the healthcare centre, to wait for an escort. Oscar 1 arrived at the man's cell and realised that he was in a very serious condition, so he told the communications OSG to call an ambulance. The time was 2.39am.

43. At 2.40am, the nurse arrived. She immediately checked for a pulse, but could not find one. She also noted that the man's pupils were fixed and dilated. She took over the compressions from Oscar 2. As she worked, she noticed the cellmate sitting on the top bunk and she asked staff to take him out of the cell. The staff continued with CPR for a further ten minutes until the paramedics arrived. One of the paramedics took over the breathing from Oscar 2. She and the nurse worked together for a further fifteen minutes. However, they decided that nothing further could be done for the man and the paramedics pronounced him dead at 3.08am.

44. The Governor one of the family liaison officers visited the man's mother and grandfather to beak the news of his death. The man's mother told my family liaison officer that she was very grateful for the information the prison family liaison officer had provided and for her continuing care and support to the family.

ISSUES

Cell Sharing Risk Assessment (CSRA)

45. A number of staff interviewed the man in reception on the morning of his arrival. An officer spoke to the man as he completed several of the necessary forms, including the CSRA. This questionnaire aims to identify any risk a prisoner may pose to another prisoner, to help officers allocate new prisoners to a cell. The assessment is usually completed by both healthcare and discipline staff.

46. The officer asked the man the questions on the first part of the form and ticked the relevant boxes. However, a number of the man's answers were different to the information contained on the PER form. The officer recorded what the man told him, rather than using the information on the PER form. He told my investigators that the PER form was attached to the CSRA before it was sent to the induction unit. He did not want to copy out a lot of information from the PER form onto the CSRA and expected the induction staff to read both documents. Reception staff often have to interview many prisoners in a fairly short space of time and it is time-consuming to transfer information from one document to another. Similarly, the induction unit also accept many new prisoners onto the unit at a time.

47. Where the PER form highlights important information about a prisoner, especially if it is at odds with information on the CSRA, it would be helpful for the reception officer to draw attention to it and if necessary, question an individual further. This could be achieved by making a brief note in the section of the CSRA for observations and concerns. That way, induction unit staff would be alerted to the importance of information on both the PER form and any other documents accompanying the prisoner.

The Governor should ensure reception staff draw attention to any conflicting information when completing the CSRA.

ACCT

48. When the duty doctor saw the man on the morning of his first full day in Hull, she was concerned about both his physical and mental health. Physically, he was beginning to suffer the effects of alcohol withdrawal. The doctor therefore prescribed medications for a standard detoxification programme. When she asked whether he had self-harmed in the past, or if he felt like doing so at present, the man's reply caused her to open an ACCT plan.

49. When an ACCT plan is opened, a case manager is appointed and staff must also draw up an immediate action/support plan. Within 24 hours, a full assessment must take place. The wing senior officer drew up the action plan and carried out the assessment shortly after the doctor passed the ACCT document to him. The speed with which this was done is commendable. Hull has added an additional page to the booklet that contains all the information, assessments and observations. It contains instructions to staff. The instructions emphasise the

quality that is expected and examples of both good and poor entries are given. A copy of the instructions appear at Annex 5

I commend as good practice, the information sheet used at Hull that describes and gives examples of what makes a good entry in an ACCT plan.

50. That said, staff do not appear to have considered contacting the man's family to include them in his support plan. PSO 2700 Suicide and Self-harm Prevention states in paragraph 3.4.3, "After consultation with the prisoner, the nominated next of kin must be notified, unless:
    a. There is a clinical reason not to, or
    b. If aged 18 and over, the prisoner does not consent, or
    c. The prisoner's support plan indicates otherwise."

There is nothing on the record to show that staff considered encouraging the man to include his family in his support plan.

The Governor of Hull should remind staff of the requirement, in PSO 2700, to consider involving the family in the support of a prisoner on an ACCT plan and introduce an audit of records to establish compliance.

51. The senior officer who assessed the man told my investigators that during their conversation, the man was focussed on his court appearance the following week. He was convinced that the evidence would prove his innocence and that he would be freed. The senior officer's concern was that if the man returned to prison, he would be at heightened risk of self-harm. The senior officer therefore decided to keep the ACCT open until after the court date. He scheduled the next review of the ACCT for the day after the man was due to return to court. It would have been helpful to other staff if the information about his court date had been noted on the section for triggers/warning signs.

The Governor of Hull should remind staff to enter triggers such as court appearances in the relevant section of the ACCT.

Access to phone cards

52. When the man arrived at Hull, the reception officer asked him during the reception interview whether his family knew where he was. When the man said no, the officer telephoned the man's grandfather on his behalf. The man faced a charge of harassment and so was not permitted to use the telephone until the numbers he wished to call had been cleared. The process to approve the numbers involved checking them to ensure that they did not belong to people he was banned from contacting. It took staff two days to carry out the checks and the man was not able to use the telephone until then. I find two days to check the man's telephone numbers to be a reasonable length of time.

53. However, on arrival, the man d had asked, as a matter of urgency, to contact his solicitor, to discuss the charges against him and the evidence that he was convinced would prove his innocence. He was very frustrated at not being able

to contact them immediately. In a letter dated on his third day in prison, 'between 14.30pm and 17.00pm' found in his cell after his death, he protested at being unable to use the telephone. He spoke to a chaplain about this the same afternoon and by the end of the conversation he was shaking.

54. My investigators raised the issue of the man's great desire to speak to his solicitor with one of the wing senior officers. He said that it would be almost unheard of for staff to allow a prisoner to use an office telephone to contact their solicitor. Prisoners who need to speak to their legal representative have three ways of doing so. They can make an application for a letter which they can then send to the solicitor. They can also get the number put on their list of approved PIN phone numbers or they can ask a family member to contact the solicitor. The man did not have enough time before the court date to make the application, receive the legal letter, send it to his solicitor and then wait for a reply. Neither had he given the solicitor's number for his PIN phone, so he could not use that method of contact.

55. However, once he was able to speak to his mother, he was able to ask her to deal with the solicitor on his behalf. Given that the man was on an ACCT plan and the imminence of his next court date, it seems unduly stringent not to consider making an exception, to help put his mind at rest. The Governor may wish to consider whether, in cases such as the man's, a legal aid fax could be offered or a system put in place for contact to be made using an official telephone.

Medical Care

56. The clinical review was undertaken by a member of Hull Teaching Primary Care Trust (PCT). He concluded that the clinical care the man received in prison was at least as good as the care he would have received had he been in the community. He said that the drug detoxification programme that the man was prescribed was appropriate and all ACCT procedures were completed in a timely manner. However, he highlighted three learning points.

57. Some of the forms in the man's medical record were incomplete. They did not have all the personal details filled in and in one case the person completing the document did not initial or date the form.

The Prison Health Partnership should take steps to ensure the healthcare staff adhere to the guidance on records and record keeping, issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.

58. The other two points relate to assessing the seriousness of previous self-harm attempts. The reviewer suggests that it would be good practice for healthcare staff to go further in gathering information than the current First Reception Health Screen form requires. He proposes that staff should not simply ask prisoners about the incidence of recent serious self-harm attempts. They should also ask for details and record how serious the attempt was. That way, staff could develop a profile of what triggers that prisoner to harm himself. Similarly, he

suggests the setting up of a risk protocol to record prisoners who were at risk and how serious the risk was. The assessment could then help prioritise referrals to the Mental Health Inreach Team. Whilst not making an official recommendation, the Head of Healthcare may wish to consider adopting these practices as a means of further identifying and supporting prisoners who are at risk of self-harm.

59. Two further healthcare issues came to light when looking at the attempt to resuscitate the man. These concern healthcare staff who work night shifts. My investigators interviewed the nurse who went to the man's aid after the Code Blue call. The Staff Nurse is an agency nurse who often works at Hull. She is a Registered Mental Nurse (RMN), which means that her area of expertise is caring for people with mental health problems. However, at Hull she sometimes performs more general duties, including dealing with men in poor physical health. On the night the man died, there were two nurses on duty and both were RMNs.

    The Head of Healthcare should ensure that, wherever possible, one of the night shift nurses is a Registered General Nurse to ensure an appropriate skill mix of staff.

60. The nurse responded to the Code Blue as part of her duties as Hotel (H) 1, the response nurse. When she heard the call for assistance, she asked her colleague to fetch the defibrillator that is kept the healthcare centre. A defibrillator is a machine that supports the treatment of patients who experience sudden cardiac arrest, by delivering a shock to the heart. The nurse's colleague could not find the machine and even if she had, the nurse was not very confident in using it. However, this did not adversely affect the treatment that the man received.

    The Head of Healthcare should ensure that all night duty nurses, whether permanent or agency staff, are trained in CPR, including the use of the defibrillator.

Finding the man

61. The documents that detailed finding the man revealed two different times - 2.10am and 2.34am. Having examined the apparent discrepancy, I am content that there was no delay in staff attending the man and attempting to resuscitate him.

62. The officers and nurse who found the man and went to his aid all estimated the time that they became involved. When asked, none of them said they had made a note of the time or looked at a clock or watch. Understandably, their immediate concern was to tend the man. The staff who gave the time as 2.34am, used the time recorded in the control room log.

63. The OSG on duty in the control room that morning said that as soon as he heard the Code Blue call on the radio, he looked at the clock above his desk. The time was 2.34am and he entered this on the log. He gave a very clear account of his actions after hearing the call and he was sure that the time was accurate. During the investigation my staff checked the clock. It was accurate and in a very

prominent position. On balance, I conclude that the man was found at 2.34am, somewhat later than the estimates of the first staff on the scene.

The man's cellmate

64. In the first few days after the man's death, concerns were expressed about whether his cellmate had been involved in any way. There was a rumour in the prison that the two men had taken drugs obtained from another prisoner. A second rumour was that the cellmate had told an officer that he had helped the man cover the observation flap. The cellmate was released on bail a few days after the man's death and my investigators did not have an opportunity to speak to him as he left no onward address.

65. At the time of writing this report, the post mortem report was not available. However, the toxicology report showed that the man had not used alcohol or drugs, other than the medication he was taking for the detoxification programme. Therefore, the first rumour was clearly untrue.

66. My investigators spoke to a number of staff about whether the cellmate had known the man's intentions and had helped to cover the observation flap. When the OSG checked the man at 1.00am, he was writing and appeared settled. The OSG was not able to say where the cellmate was, as his attention was on the man. At 2.34am, when he entered the cell with Oscar 2, they were only vaguely aware of the cellmate. The OSG assumed that he must have been in his bed because he was not in their way. Oscar 2 said that the cellmate was in his bed when they entered the cell and when they started to move about, the noise woke him up. He then appeared disoriented and shocked by what was happening.

67. After the man's death, prison managers were informed of the rumour of the cellmate's involvement. My investigators spoke to three members of staff in an attempt to identify the source of the information. A senior officer told my investigators that she heard a female officer and other officers discussing the two rumours the day after the man's death. Three days later, she realised that this had not been officially reported and she then submitted a security information report. Prison managers then passed the information to my investigators and the police liaison officers. No further issues have been raised by the police. The female officer said that she had spoken about the rumour that the cellmate knew what the man had planned to do, but that was all. She said that the whole prison was talking about this rumour. However, she said that she had not heard the rumour that the two men had taken drugs or that the cellmate had helped by covering the flap.

68. When my investigators asked one of the A wing managers, about this, he expressed surprise and said he had not previously heard the rumour. Certainly, no officer had reported that the cellmate had admitted assisting the man. The manager was very clear that all he had heard after the man's death was some prisoners talking to each other, questioning whether it was possible to sleep through such an event. He did not hear officers talk about it until senior managers questioned the officers concerned. The senior managers then passed the matter to my investigators. My investigators could find nothing concrete to

link the cellmate to the man's actions. The rumour may well have started as speculation about whether it is possible for someone in the same cell to be unaware of a cell mate taking such action. Therefore, I conclude that this was simply speculation.

Conclusion

69. The man who died was a young man who was obviously labouring with his addiction to alcohol and the difficulties of a relationship which was breaking down. He was also struggling to accept being back in prison under circumstances which to him felt unjust and flawed. His anger at being in prison was equalled by the conviction that his innocence would be proved when he returned to court. Sadly, he did not live long enough to set out his case.

RECOMMENDATIONS

The Governor should ensure reception staff draw attention to any conflicting information when completing the CSRA.

This recommendation was accepted. All staff are to be made fully aware of the requirement to cross reference information contained on the Prisoner Escort Record (PER) form when completing the Cell Sharing Risk Assessment (CSRA).

The Governor of Hull should remind staff of the requirement, in PSO 2700, to consider involving the family in the support of a prisoner on an ACCT plan and introduce an audit of records to establish compliance.

A detailed response was not provided for this amended recommendation.

The Governor of Hull should remind staff to enter triggers such as court appearances in the relevant section of the ACCT.

This recommendation was accepted. The importance of trigger points in ACCT documents forms part of the training module, and the daily management of the ACCT document. All open ACCTs are subject to a full assessment by trained assessors within 24 hours of opening and identified triggers, if appropriate, noted.

The Prison Health Partnership should take steps to ensure the healthcare staff adhere to the guidance on records and record keeping, issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.

This recommendation was accepted. All healthcare staff have been issued with a copy of the Nursing and Midwifery Council (NMC) guidelines on record keeping, and training around this subject is now part of the performance review of each member of staff. Since April '07, a phased introduction of electronic patient records has been started, which will ensure all entries are legible.

The Head of Healthcare should ensure that, wherever possible, one of the night shift nurses is a Registered General Nurse to ensure an appropriate skill mix of staff.

At the time of issuing the final report, a response had not been supplied by the Prison Service.

The Head of Healthcare should ensure that all night duty nurses, whether permanent or agency staff, are trained in CPR, including the use of the defibrillator.

This recommendation was accepted. All nurses including bank nurses are included in the yearly training performance reviews. Basic life support training is mandatory for all nurses. However, the nurse in question has undertaken this training and it is her responsibility to bring any issues in regard to her own confidence to the attention of her line managers.

Good practice

I commend as good practice, the information sheet used at Hull that describes and gives examples of what makes a good entry in an ACCT plan.

ANNEXES

1. Documents considered during the investigation

   Core Record
   Custody File
   Security File
   Medical Records
   Records from the man’s previous period of imprisonment