PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Hull in March 2011

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

This is the report of an investigation into the death of a man. He was found in his single cell at HMP Hull in March 2011 with a ligature around his neck and a plastic bag over his head. He was 44 years old at the time of his death.

I extend my condolences and those of my colleagues to the man's family and friends for their loss. I hope this report goes some way to answering any questions they may have. I regret that my report is delayed and apologise for any additional distress that this may have caused.

The investigation into the man's death was undertaken by a senior investigator from this office. In addition, a clinical review was conducted by a clinical reviewer on behalf of the local PCT. I am grateful to the Governor of Hull and his staff for their co-operation with the investigation.

The report makes disturbing reading. The man was clearly a troubled man with a range of issues and vulnerabilities. Amongst these was the high risk of self-harm identified in police custody and subsequently, on more than one occasion, by escort staff. Yet a range of staff at Hull prison were, for a variety of reasons, unable to pick up on this information in their own assessments of him. He therefore never benefited from the closer attention that the prison's suicide prevention arrangements would have afforded, including potentially greater involvement with mental health services.

We therefore make a number of recommendations to address these issues. We also recommend improvements to emergency procedures, although it should be added that the investigation found that staff responses were prompt and healthcare generally appropriate. Finally, it is a matter of regret that the man's family do not feel well served by the prison in a number of ways. We make one recommendation as to how liaison might be enhanced in future. We also note that, initially, the prison did not contribute to the family's funeral expenses to the extent we would expect given the National Offender Management Service's policy and normal practice. However, following our intervention, this matter was satisfactorily resolved.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2012**

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SUMMARY

1. On 3 February 2011, the man was arrested by police and spent four days in police custody. On 7 February, having appeared at Magistrates' Court, he was transferred to HMP Hull. Documentation accompanying him indicated that he was at a high risk of harming himself. Assessments completed by both police and court staff noted that he was taking methadone (a heroin substitute), suffered from depression and had recently attempted to take his own life. Whilst in the custody of both the police and the courts, he remained under constant supervision. (Constant supervision, or observation, as it is called by the police, is where an individual identified as being at a high risk of harming themselves, is watched continuously.)

2. Despite reception officers having access to the documentation that accompanied the man, indicating that he was considered to be at high risk of harming himself and had been under constant supervision, no Assessment, Care in Custody and Teamwork (ACCT) procedures were implemented. (ACCT is the prison system for identifying and supporting those at risk of suicide or self harm.)

3. The man was also seen by a nurse in reception who carried out an initial assessment of his medical needs. The nurse identified that he would require detoxification medication but noted that he had not tried to harm himself either in or outside of prison.

4. The man had sustained head injuries at the time of his alleged offence. As a result of these injuries and given that he had been identified as requiring detoxification treatment, he was located for his first night in prison on the healthcare unit before being moved to the prison's detoxification wing. During the short period of time that he spent at Hull he received treatment for his drug addiction and physical injuries. He stayed on the prison's detoxification unit and appeared to settle into prison life. However, he was described as an 'introvert', preferring to keep his own company.

5. On 14 February, the man appeared at court. Whilst at court, escort staff became concerned with regard to his well being and completed a form to notify prison staff that they had identified him as being at an increased risk of harming himself. Although this form was acknowledged by staff in the prison's reception, he was not assessed by the reception nurse.

6. At the beginning of March the man was found by an officer lying on the floor of his cell. He had apparently tied a ligature around his neck and placed a plastic bag over his head. The officer raised the alarm and colleagues and healthcare staff immediately attended. However, the responding nurse did not attempt resuscitation because there were no signs of life. He was pronounced dead by paramedics shortly before 8.30am.

7. The review into the medical treatment the man received in custody concludes that it was equitable to that which he could expect in the community. However,

throughout his time in prison, no formal assessment of his mental health needs was made.

8. The report examines a number of areas of concern surrounding the circumstances of the man's death. Several of the recommendations made relate to the assessment by staff in reception of his risk of self harm. I also make recommendations with regard to the sharing of information and the request of records from medical professionals in the community. Although, the immediate response to him being found by staff was prompt, I make several recommendations relating to this, including the prompt calling of the emergency services.

THE INVESTIGATION PROCESS

9. A senior Investigator from this office was appointed to conduct the investigation into the circumstances surrounding the man's death and was assisted during interviews by another investigator. He opened the investigation on 8 March 2011, when he visited HMP Hull. He met the Deputy Governor and other members of the prison management team. He also met a representative from the Prison Officers' Association (POA) and a member of the Independent Monitoring Board (IMB). (IMB members are independent and unpaid. They monitor day to day life in the prison to ensure that proper standards of care and decency are maintained. The POA is the trade union for prison officers.)

10. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Hull. The notices were displayed around the prison and invited staff and prisoners to contact the investigator with any information relevant to the investigation. No prisoners came forward to speak with the investigator.

11. The investigator was shown the cell and wing where the man spent the last weeks of his life, as well as visiting other areas of the prison, including the reception area. The investigator reviewed his prison and health records and other documentation relating to the time that he spent at Hull. The investigator asked for copies of all telephone calls to be forwarded, however he made no calls during his time in custody.

12. Both investigators conducted a number of interviews with staff on 11 to 13 April. The prisoners who occupied cells either side of the man were not interviewed as they had been released from the prison. During the course of the investigation, the investigator provided verbal feedback to the Deputy Governor, confirming this in writing to the Governor of Hull.

13. A clinical review was commissioned from the local PCT. A clinical reviewer completed this on behalf of the PCT and the Ombudsman is grateful for his assistance in this matter. The clinical review is the first annex to this investigation report.

14. The investigator also liaised with a Detective Sergeant and a Detective Constable from Humberside Police, who were acting on behalf of the Coroner. They confirmed that the police were not treating the death as suspicious and were happy for the Ombudsman's investigation to go ahead. The Ombudsman is grateful to the police for sharing relevant information with the investigator. The investigator also contacted the Coroner's Office and a copy of this report will be sent to the Coroner to assist him with his enquiries.

15. We offer our apologies for the delay in finalising this report, which was due to workload issues.

16. One of the Ombudsman's family liaison officers contacted the man's family informing them of the nature of the investigation. He invited them to raise any concerns or questions about the man's time in custody that they wished to be

addressed as part of this process. On 25 March, the family liaison officer had a lengthy conversation with the man's brother, who was representing other members of the family, when he raised a number of issues and concerns, including the following issues.

- At the time the man entered prison he was very unstable and that a referral to Broadmoor had been considered a number of years previously. He had asked what safeguards the prison put in place when his brother first arrived at Hull, given that he had been on "suicide watch" whilst in police custody, and specifically asked whether he had been put on "suicide watch" at Hull?

- The family were initially told that the man had hanged himself, but in a subsequent meeting they were told by police that he had put a bag over his head. The family said that this misinformation had caused the family additional distress as it had come as a complete shock when they were told what had actually happened.

- The family also commented that although some of the funeral expenses had been paid by the prison, others, such as the cremation and payment of clergy to officiate, had not.

17. A number of issues relating to the return of the man's property were also raised by his family. We understand that these issues have now been dealt with and the property returned. However, the family said that a gold chain which he owned was missing. Despite making enquires with regard to this matter the investigators have been unable to establish what happened to the gold chain, which he had signed, to agree, to hold at his own risk whilst in prison.

18. It is hoped that the report answers these and any other questions that the family may have.

HMP HULL

19. HMP Hull is a category B local prison holding remand and sentenced adult male prisoners and young offenders. (Category B prisoners are those for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult.) Hull serves courts in the Yorkshire, Humberside and North Lincolnshire areas. The prison is made up of eight residential units. Since 2002, the prison has undergone a period of expansion and now holds over a thousand prisoners. As with all local prisons, it is under constant pressure to accommodate the large numbers of prisoners that make up its ever-changing population.

Assessment, Care in Custody and Teamwork (ACCT)

20. ACCT is the prison system for identifying and supporting those at risk of suicide or self harm. ACCT procedures are pivotal in the management of at-risk prisoners. The ACCT document is the principal tool for assessing, monitoring and managing any prisoner thought to present a risk of self-harm or suicide. ACCT procedures can be initiated by any member of staff, irrespective of grade or discipline. The ACCT form itself contains instructions and guidance for its use. If a member of staff has reason to believe that a prisoner is at risk of self-harm or suicide, he or she must open an ACCT form straightaway.

Mental health services at HMP Hull

21. The Mental Health In-reach Team (MHIRT) provides secondary care for those with severe and enduring mental illnesses. The Primary Care Mental Health Team (PCMHT) provides support and care for those suffering from issues such as depression and anxiety. Any one can make a referral to mental health services and those with a psychiatric, or acute self harm issues, can be referred directly on reception.

Integrated Drug Treatment Service (IDTS)

22. Integrated Drug Treatment System or IDTS is an initiative that aims to improve and increase the volume and quality of clinical treatments for substance misuse available to prisoners. Its aim is to ensure that professionals work together in the coordination of a prisoner's care, with particular emphasis on the first 28 days of their custodial experience. This is achieved by increasing the range of treatment options available in prison, which includes the prescription of drug substitutes for those with addictions to heroin and other opiates. (Opiates are sedative narcotics containing opium or one or more of its natural or synthetic derivatives.) Other aims include: combining clinical and psychological treatments in prison into one system, and reinforcing continuity of care from community drug intervention programmes into prison, between prisons, and on a prisoner's release back into the community.

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

23. CARATs, stands for Counselling, Assessment, Referral, Advice, and Throughcare services and provides drug misuse intervention services in prisons. The service is made up of drug workers based in most prisons from organisations specialising in the treatment of substance abuse. CARATS workers can run programmes, and offer counselling, support and referral to rehabilitation centres to prisoners. Engagement with CARATS is voluntary.

24. A member of the CARATS team at Hull sees all prisoners in reception to ascertain whether they have any substance misuse problems. They explain the purpose of IDTS and assess prisoners for substance misuse issues including alcohol and drugs. If a prisoner has substance misuse needs, they are assessed by an IDTS nurse in reception, who also assesses their mental health. If the prisoner does not need substance misuse intervention, they are given a first night reception healthcare screen by a nurse on the prison's induction unit. (All prisoners are given a first night reception health screen when entering prison. The aim of the screen is to identify any needs or health concerns that the prisoner might have. It includes identifying a prisoner's past medical history, including mental health.)

Integrated Drug Treatment Service (IDTS) and mental health

25. At the time of the man's death, the PCMHT did not accept referrals for prisoners who were located on the Integrated Drug Treatment Service (IDTS) unit. At the time of his death prisoners going through detoxification would not be referred to the PCMHT for the first two weeks of their location on the IDTS unit. The Head of IDTS explained that it was preferable for a prisoner's withdrawal symptoms to be stabilised before a thorough assessment of their mental health needs could be made. The rationale behind this being that symptoms of withdrawal prevent an accurate assessment of mental health needs. (Since his death, this window of referral has been reduced to five days.)

26. Many of the nurses working on the IDTS unit are mental health nurses and, in addition to providing IDTS programmes, they can also provide primary care mental health treatments. If a prisoner is previously known to psychiatric services in the community, then a direct referral to the MHIRT should be made.

HM Inspectorate of Prisons Report 2008

27. The last inspection by Her Majesty's Chief Inspector of Prisons was an announced inspection by the then Chief Inspector in November 2008. At the time of her inspection, she reported that the prison, despite population pressures, "… was performing reasonably well… ". However, she reported that more resources were needed to support safer custody work … to ensure that suicide prevention procedures were sufficiently robust and consistent.

Previous self inflicted deaths at HMP Hull

28. The man's death is the fourth apparently self-inflicted death at Hull since the Ombudsman started investigating deaths in custody in April 2004. Another apparently self-inflicted death has occurred since his death.

29. In this report we make a similar recommendation to one made by this office into the death of a man at the prison in 2008, with regard to requesting previous medical records from the community, especially when a prisoner is identified as suffering from mental health issues.

KEY EVENTS

30. The man had a long history of alcohol and drug use. His community health records, obtained by the clinical reviewer after his death, indicate long standing anxiety, depression and difficulty in coping with the outside world. His medical records indicate that he probably had a personality disorder and had previously been referred to Rampton secure mental health unit in 1993/4. Other psychiatric referrals and reports also note that he had been seen by numerous psychiatrists. General Practitioner (GP) notes made in January 2011 indicate that he suffered from,

> "low mood. Poor sleep. Denies heroin use but taking prescribed methadone regularly. Thoughts of a suicidal nature and a belief he would be better off dead."

31. On 3 February 2011, the man was arrested by Humberside Police and charged with wounding with intent to cause grievous bodily harm and with the possession of an offensive weapon. Having received a number of injuries during the alleged offence, he was taken to hospital for treatment.

32. The following evening, the man was taken into police custody at Grimsby police station. A police officer completed a risk assessment to determine among other things whether or not he was at risk of harming himself. The reviewing police officer noted that he had received a number of injuries, including a cut to his forehead, for which he had received stitches. He told the police officer that he was taking trazodone for depression. (Trazodone is also used as a sedative and is sometimes given to those who are agitated or have difficulty sleeping.) He also told police that he was taking methadone to manage his heroin withdrawal symptoms.

33. The man said he had intentionally injured himself, by banging his head against a van and had attempted suicide within the last two weeks by injecting heroin. However, he told the police officer that he had no current thoughts of harming himself. As a consequence of the risk assessment, he was placed under constant supervision, and was observed by a police officer at all times. Later that evening he refused an examination by the doctor working for the police, but was nevertheless prescribed antibiotics and painkillers for his injuries. The doctor assessed his risk of harming himself as high.

34. On 5 February, the man was again assessed by a police doctor. The doctor noted that he suffered from a history of depression and drug misuse and said that he felt suicidal at the time of the assessment. He recorded that he needed a mental health assessment and his risk of self harm continued to be high. He remained on constant supervision. On 6 February, he was seen by the police doctor twice. Following these further assessments, his risk of self harm was assessed as standard.

35. On the afternoon of 7 February, the man was taken into the custody of G4S for transfer to Magistrates' Court. (G4S manages and operates services for transferring prisoners between prisons, police stations and courts in the

Humberside area.) As with all transfers, a Prisoner Escort Record (PER) was completed. (The PER accompanies all prisoners on journeys from and between prisons, courts and police cells, and serves as a communication tool for all staff working at such establishments. It provides a chronological record of events and records any risks that prisoners may pose to themselves or others during a transfer.)

36. A Police Custody Detention Officer (CDO), prepared the PER for the man's transfer the evening before his court appearance. On the front of the PER, the CDO provided extensive details of his risks. He recorded that, on 3 February, the man had banged his head on the cell wall and had removed stitches from his head wound. The officer described him as "violent/volatile and unpredictable whilst in custody". The CDO also noted that, on 5 February, he had stated that he would kill himself whilst in prison and that the following day had threatened to kill medical professionals whilst in custody. The CDO also recorded on the PER that he had been on a "constant cell watch" throughout his detention because of his violent and unpredictable behaviour. The officer explained that he had been in receipt of methadone, was prescribed medication for depression, and had a head injury, but, "… had been deemed mentally well".

37. At 3.47pm, a Person Custody Officer (PCO), an escort officer working for G4S, wrote in Part B, Record of Events section of the PER, that the man was:

> "…of a volatile nature and extremely aggressive, he has banged his head on numerous occasions in custody he has stitches in his head at present which he keeps trying to remove. He is totally unpredictable, hence he has been on a constant watch whilst in custody, there is a real risk to both himself and officers also to the fabric of the court."

38. At about the same time, another PCO opened a Suicide Self-Harm Warning Form, used by court and escort staff if a prisoner is assessed at risk of harming himself. In section two of the form, 'Nature of the Concern', the PCO reported that the man had said that he intended to self harm, showed bizarre behaviour and seemed very depressed. The PCO wrote that he showed signs of drug or alcohol withdrawal and had made attempts to harm himself within the last month, and since his arrest. He also noted that he had, "Banged head on cell wall. [and] Has been removing stitches from head wound".

39. In section four of the warning form, 'details and initial observations', the PCO repeated the description of the man originally written by the first PCO in part B of the PER. In section five of the warning form, 'actions undertaken to ensure safety whilst in pre/inter-prison custody', the PCO Indicated that he was to remain on constant supervision and that a Senior Officer (SO) (a reception senior officer at Hull) had been, "… informed of prisoners demeanour and condition." During interview, the SO told the investigators that he makes a note of such conversations with G4S on a piece of paper in the reception area to remind himself when the prisoner arrives at the prison.

40. The man was transferred from the Magistrates' Court to be remanded in custody at Hull at approximately 5.30pm. During the transfer he was placed in a cell on the escort van which enabled him to be observed constantly during the transfer by PCO Maguire. He arrived at the prison an hour later at 6.35pm.

41. Officer A, one of the officers working in reception that day, told the investigator that she was unable to recall her dealings with the man. However, she explained that all prisoners are taken from the G4S escort van one at a time and brought into Hull's reception. On arrival in reception, she said that prisoners would be then asked to sit on the Body Orifice Security Scanner or Boss chair (a highly sensitive metal detector which introduced to reduce the need for intimate body cavity searches), before being placed in one of two immediate holding cells. (These cells are called holding cell one and holding cell two. The cells are similar to those found in the main prison and contain bench seating, but no other facilities. The doors to these cells are solid, with a small observation flap.)

42. The officer explained that once all the prisoners have been brought into reception and placed in one of the two immediate holding cells they would be called, one at a time in the order of their arrival, to the reception desk. She said that whilst prisoners were held in the immediate holding cells, staff would not be aware as to their identity or whether they were on an open Suicide Self-Harm Warning Form.

43. Once the prisoner is called to the reception desk, the officer said the prisoner's PER would be checked to ensure the correct property had been received. She said that if a prisoner has a Suicide and Self Harm Warning form, it is at this point that the reception officer will sign to confirm that the prisoner will be kept safe '… according to local protocols until passed to healthcare screening'. According to the man's records, she signed both forms at 7.20pm, 45 minutes after his arrival at the prison.

44. During interview, the officer said she does not consider opening an ACCT just because the prisoner arrived at the prison on a Suicide Self-Harm Warning form. She explained that G4S staff draw prison staff's attention when there is a prisoner at particularly high risk, either before their arrival at the prison, by telephone, or whilst being escorted from the van. She said that if she had any concerns about what was written on a Suicide Self-Harm Warning form she would mention it to the senior officer on duty.

45. The officer said that the senior officer at the reception desk would then check the prisoner's warrant and allocate a prison number before placing him into one of the two holding rooms. (The holding rooms are larger than the holding cells, have toilet facilities and large glass windows in which officers in reception can see through.)

46. From the holding rooms, the man was called by Officer B. The officer told the investigation team that he would have collected the man's 'basket', (a tray containing the records from police custody, court and escort staff) and taken it

to one of the booths in reception where prisoners are interviewed.

47. The officer went through the man's paperwork with him and confirmed the information on his warrant and PER. His property was also processed at this stage. The officer also completed a Cell Sharing Risk Assessment (CSRA - an assessment used to determine the risk that a prisoner would present to others when sharing a cell.) The officer recorded that the man got angry easily and had concerns about sharing a cell, stating that he did not wish to share and would, "… attack anyone if put in a cell with them". He was assessed as being of a high risk and as such would require location in a single cell.

48. During his assessment of him, the officer said he considered his Suicide and Self Harm Warning form and whether he should start ACCT procedures for him. During interview the officer told the investigators that the man:

> "… was quite vocal, he was very colourful I was having good eye contact with him and certainly he wasn't low in mood when I saw him. He was quite alert and speaking to me as I'm speaking to you now."

He said:

> "To say the least and he was quiet from memory, quite jovial with me and basically [we] went through what was written down on the PER, that was written down on the warning form and he didn't want to share a cell and he made that very, very clear … I do remember going through all the information that was written down and obviously on the PER and the warning form there was issues about him saying about killing himself and he basically said to me that he didn't like the institution, he didn't like police and there's things that he just said because he didn't want to come to jail."

49. The officer said that once he had finished interviewing the man he would have stapled the Suicide Self Harm Warning Form to the front, outside cover, of the F2050 Core Record, (a reception record completed for all new prisoners). He would have placed the CSRA on the top, for staff on the wings to see it. He said that once he had interviewed him he would have given his records to the IDTS nurse. He said he spent about half an hour with him.

50. Shortly before 8.00pm, the man was given a first night reception health screen by Nurse A, a registered mental health nurse (RMN) from the IDTS team. He had earlier been assessed by a member of the CARATs team as someone with substance misuse issues and, as such, eligible to be assessed by an IDTS nurse in reception. The nurse noted that he had been given dihydrocodeine (a strong painkiller) whilst in police custody and noted the details of his GP.

51. The man told the nurse that he had also been given diazepam whilst in police custody and had concerns about the effects of substance withdrawal. (Diazepam is often used for the short-term relief of symptoms related to anxiety disorders.) He told the nurse that he had, until 3 February, been receiving

60mls of methadone daily and had tested positive for methadone.

52. According to the health screen, the nurse recorded in the man's medical record that he had previously been in prison and that no medical information had been received from 'outside sources' (medical records held in the community.) He noted that he tested positive for opiates. The nurse explained the prison's 'out of treatment policy' for methadone. The out of treatment policy states that if a patient has not received methadone for three days they are considered to be 'out of treatment'. For those out of treatment (like the man), the doctor will prescribe a low dose of detoxification medication, and then increase the dosage slowly over a number of days. Symptomatic relief medication is used to assist with possible pain relief, cramps, vomiting and other symptoms associated with drug detoxification. The nurse made a referral for him to be seen by the substance misuse doctor and the prison's drug services team.

53. The nurse also noted that the man had not tried to harm himself either in or outside of prison. He described him as settled in mood and wrote that he interacted well, presenting with no "abnormal behaviour". The nurse recorded that no medical or psychiatric reports were required, but that he had previously received treatment from a psychiatrist whilst in the community, and had been prescribed trazodone for mental health issues.

54. During his assessment of the man, the nurse signed section eight of the Suicide Self-Harm Warning Form, and indicated that he had not started ACCT procedures for him. The nurse also completed the healthcare section of the CSRA. He noted that the man was, "Quick tempered and volatile [in] mood", and that, following the self harm assessment, no concerns had been raised.

55. During interview, the nurse told the investigators that the man was "…quite settled that night. His main concern was his medication…" The nurse said he did not believe that he required any support with regard to his mental health at that time. He said:

> "… he didn't appear to warrant the need for an ACCT at that time on reception. He explained that he was frustrated, he was angry, he had no intention of harming himself and that's why he behaved the way he did."

56. The nurse said that the man could not be seen by a doctor that night, because there was not one on duty due to staff sickness. Therefore, the nurse made arrangements for him to be located in the healthcare unit as opposed to the IDTS unit, where he would receive close monitoring, given his recent medical history and injuries.

57. The man was provided with a first night induction, by an officer, to explain the prison's regimes and procedures. He told the officer that he did not feel like harming himself. However, during the induction process he refused to sign a number of the documents presented to him, including the rules outlining use of the prison telephones.

58. The man was admitted to the prison's healthcare centre at 9.00pm. A Health Care Assistant (HCA) noted in his medical record that he was admitted for 24 hour (medical) observation, he had various cuts and grazes to his face, but appeared settled. Later that evening, a nurse raised a care plan for him. The care plan included consideration for an ACCT document to be opened and for risk assessments to be completed. However, the investigation found no evidence that further consideration to open an ACCT was made or that a risk assessment was completed.

59. On 8 February, the nurse wrote that the man was unhappy because he could not make a telephone call in the early hours of the morning. He was also demanding tramadol, an opiate-based painkiller used to manage moderate to severe pain. He was advised he could not have the tramadol until he had seen the prison doctor. She noted no problems or concerns about his physical health during his first night on the healthcare unit.

60. At 10.00am, the man was seen by one of the prison doctors. He told the doctor that he believed he had received methadone during his recent stay in hospital. Although the doctor tried a number of times to contact the hospital, he was unable to confirm his recent prescriptions. Neither could the doctor confirm the prescription he said he had received from his GP, despite requesting it. The doctor examined the injuries to his head, noted that his pupils were dilated, that he had a slight tremor, but was cooperative.

61. The doctor concluded that the man required a course of detoxification and as a consequence prescribed a low starting dose of methadone, 20 millilitres morning and afternoon. The doctor also prescribed thiamine for the treatment of Vitamin B deficiency and a low dose of diazepam, both of which are used in the treatment of alcohol withdrawal. He was subsequently discharged from healthcare and relocated on the prison's IDTS unit. The investigators asked the doctor if, during his consultation, he had seen any evidence that the man had tried to remove the stitches from his head. The doctor said that he saw no such sign. Later that day, a HCA noted that his general well being was good and that he was alert and responsive.

62. On 9 February, the HCA noted that he was irritable, said he had slept badly and requested an increase in his medication. At 6.15pm, he was seen by a nurse who noted that he was suffering from muscle twitches, hot and cold flushes and had difficulty concentrating. He also said he was experiencing loss of appetite, numbness in his feet, stiffness in his muscles, and felt jittery from lack of sleep. As a consequence he was seen again by the doctor. The doctor observed that he seemed to be developing signs of withdrawal, for example he was emotional, mildly anxious, irritable, not eating properly, and feeling sick. The doctor noted that he could have been experiencing symptoms of alcohol withdrawal that had not previously been obvious. The doctor increased his methadone by 10mls a day to 50ml.

63. On 10 February, an officer raised a PER form for the man's forthcoming appearance at Crown Court on 14 February. He described him as violent and a suicide risk. Later that day a member of the healthcare team, a nurse recorded

the health risks relating to him on the PER. The nurse explained to the investigation team that he used the man's medical record to complete the PER and did not meet him in person. He noted his, "use of methadone", and that there were no known risks with regard to his mental health.

64. On the same day, a Healthcare Support Worker recorded in his medical record that the Health Centre where the man had been registered as a patient, sent confirmation of his medication in response to prison's request. That evening a nurse noted that he felt much better and appeared brighter and alert.

65. On 11 February, the man's personal officer wrote in the case notes on P-Nomis, (the prisoner's electronically held prison record) "Introduced myself to him and he was in good spirits and had no issues at this stage". (Each prisoner is allocated a personal officer, who is the first point of contact for them whilst in prison.)

66. The man was seen by a doctor at 9.30am. He told the doctor that his "methadone is not holding me" and that he was on trifluoperazine (antipsychotic medication) from his GP which had been prescribed for his frequent periods of agitation. He told the doctor again that he was unhappy at receiving a low dose of methadone. The doctor noted that he was alert and increased his methadone to 60mls. The doctor also prescribed the trifluoperazine and Trazodone, having received the confirmation of his prescription from the man's GP.

67. On 14 February, having been woken by staff early for attendance at Crown Court, the man was searched by prison staff and a PCO, a member of the escort staff employed by G4S, took responsibility for his escort to court at 8.10am. The PCO noted on the PER form that he was:

> "…Interviewed about suicide risk. States his brother [brother-in-law] died last week so he was upset about it. Says he has no intention of self-harm or suicide. Says he's alright. No suicide / self harm form opened. 5 x checks per hour … Place in cell 11."

68. Despite the man's reassurance that he was not thinking of harming himself, the PCO opened a Suicide Self-Harm Warning Form at 10.00am. She noted on the form that he appeared depressed due to his brother dying the previous week. Whilst in the custody of the court, he was located in a cell with another prisoner and was checked five times an hour. (This was the first time that information relating to the death of his brother had been noted.)

69. After his court appearance, the man returned to HMP Hull at 2.15pm where he was accepted into prison custody at 2.25pm. At 3.05pm an officer signed the accompanying Suicide Self Harm Warning form indicating that he would be kept safe according to local protocols until he was assessed by a member of the healthcare team. Prisoners returning from appearances at court are not routinely seen by a member of healthcare staff on their return to the prison each evening. However, prisoners are reviewed on their return from court if there is a change in their circumstances. This could include their conviction or

sentencing. Prisoners who return to the prison on a Suicide Self-harm Warning From should also be re-assessed by a member of the healthcare team. There is no evidence that he was seen by a member of healthcare that day.

70. On 15 February, the doctor noted in the man's medical record that he had complained about the vision in his right eye, following a recent head injury. The doctor reassured him that there was no obvious problem and scheduled a review two weeks later. The doctor also noted that much of his "mental disturbance" appeared to have been related to drug detoxification and drug withdrawal issues. He noted that the man had not received the anti-depressant medication he had been prescribed because it was unavailable. However, he assessed that his agitation had passed and the antidepressant was no longer necessary. The doctor told the investigators, "… I think I must have felt that he was improving and that would have included his mental health".

71. The investigators asked the doctor if he was ever concerned about the man's risk of harming himself. He said that given he had not made any specific entry in his medical records he did not believe it to be an issue. He said that had he thought he was at any risk of harming himself he would, "… have looked at opening an ACCT document".

72. On 17 February, another doctor noted the man's continuing symptoms of withdrawal, including aching and poor sleep at night. The following day, his methadone was increased to 65mls a day. On 22 February, he was prescribed Omeprazole, for the treatment of stomach acid.

73. On 27 February, an officer noted in the man's case notes on P-Nomis, "Introduced myself to him he had no issues to note, mixing well". He remained on the IDTS unit and settled into the regime. An officer working on the unit told the investigators that:

> "Discipline wise he wasn't a problem. I can't remember him being a problem at all but he was very, very unsteady shall we say and unstable shall we say. So he was time consuming with healthcare I would say rather than ourselves."

74. A Senior Officer (SO) told the investigators that the man was a little refractory, (resistant to authority or control), when he arrived, however, he quickly stabilised on receiving his medication. The SO said, "Once he'd actually got his meds after a couple of days he was good as gold. He was as good as prisoner as you could get". The SO also said that the man:

> "… was more of an introvert. He came out he didn't actually spend all his association period inside but he didn't mix with the same people all the time so yes he was a bit of a loner."

He said that he was not aware that the man had any "friends" on the wing.

75. On 1 March, at 9.15am, the man was observed by an officer fighting with another prisoner. The officer told the investigators that he understood the two

men had argued whilst waiting for their medication the previous day. He said that on unlock the two prisoners started fighting. The prisoner told police that the man had punched him and that staff intervened soon afterwards. The officer told the investigators that he believed the man had started the fight. Both men were placed on report after the incident. (When prison staff think a prisoner has broken a prison rule, they may put him "on report". The prisoner must be told within 48 hours what offence he is accused of having committed. A disciplinary hearing, also called an adjudication, is then held. If the charge is proved, the adjudicator imposes a penalty.) A nurse completed a Report of Injury to Inmate form, known as a F213. She noted that he had received bruising to the left hand side of his face and had said that some of his teeth were loose.

76. According to a security report submitted on the evening of 1 March, another prisoner saw the first prisoner making threats to the man through his cell door when he had been unlocked for treatments that evening. The first prisoner told police that he did not speak to him the night before his death. The investigation could find no further evidence about this exchange.

77. Officer C, the IDTS night shift officer, arrived on the unit before his official start time of 8.45pm. He said that when the evening staff had left at about 9.30pm, he carried out his first rounds, checking on those prisoners on open ACCTs and completing his pegging routines. (Pegging is an expression used by the Prison Service to describe a security procedure for accounting that an area has been visited by an officer.) He told the investigation team that at no time during his shift was his attention brought to the man and that at no point did he ring his cell bell.

2 March 2011

78. At about 5.30am, on 2 March, Officer C said that he completed his morning roll check, a security procedure to ensure that all prisoners are accounted for. In his statement, he said he checked two of the landings, but could not recall counting the ground floor landing. However, in interview for this investigation, he confirmed that he completed a check of the ground floor landing as well. The investigators asked if anything of note had happened that evening. The officer said it had not.

79. He said that Officer D, the early relief member of staff, arrived on the wing at approximately 6.30am. Although Officer D started at 6.30am, his official start time was not until 7.30am. This officer was allocated to work on the wing next door to the IDTS unit, H wing, that day. He was met by another officer, the night officer for H wing, and was told that there were no problems on the wing and that the roll was correct. He was also told by Officer C that there were no problems on the IDTS unit and that the roll for that wing was correct.

80. The two night officers then left shortly after 6.30am, leaving Officer D on his own to supervise both the IDTS unit and H wing, even though he was only detailed to work on H wing. Officer C said it was general practice that when the first relief officer for the IDTS unit or H wing arrived, the two night officers left

that officer to cover both wings. He said that he and the other officer would leave together as only one of them carried a key to exit the wing.

81. In his statement, Officer D said that about 30 minutes passed whilst he completed H wing paperwork and that he checked two prisoners on H wing who were on open ACCTs. He said that he then realised that the officer covering the IDTS unit had not arrived for the early shift so went to check the prisoners on ACCT documents on the IDTS unit.

82. When covering the early shift on a wing, the officer has to call the central office to confirm the roll on their wing is correct. By the time he had carried out the ACCT checks on both wings, the officer had still not arrived so he took the decision to confirm both the roll check for H wing, for which he was responsible, and the IDTS unit. He had not completed a full roll check for either. He told the investigation team that he used the roll counts that the other two officers had handed over to him 20 minutes before.

83. He said that the day shift officers start to arrive on the wings at about 7.45am. Officer E told the investigators that he arrived on the wing at about 7.55am to issue the man and the prisoner their adjudication paperwork for fighting the previous day. He said that he issued the prisoner his papers and then went to the man's cell at about 7.59am.

84. In his incident statement, Officer E said that he looked through the cell's observation panel and saw that the man was not near the cell door. He went into the cell and found him lying on the floor under his bed, fully clothed. He described him as underneath the bottom bunk with his legs sticking out at an angle. He said that it was a double cell that the man occupied on his own and his belongings were organised neatly across the top bunk.

85. Assuming that he was sleeping on the floor, the officer said that he called the man's name but there was no response. He called his name again with no response. The officer said he took hold of the man's leg and pulled him out from under the bed. He said that it was at this point he noticed that he had a plastic bag (prison property bag) over his head with a lace tied around his neck. The officer said the palms of his hands were blue and that his face was very red. He told the investigator that he did not remove the bag from the man's head because it seemed that rigor mortis had set in. He said he thought that the man was dead.

86. The officer said that he left the cell and returned to the centre office (about 50 metres from the cell) for assistance. The SO said he was leading the morning staff briefing in the central office when Officer E raised the alarm at about 8.05am. The SO recalled that the officer had said that he thought the man was dead. He immediately asked for a code blue to be called and instructed that both the nurse and emergency response equipment, including defibrillator (a life-saving machine that gives the heart an electric shock in some cases of cardiac arrest) should be collected and taken to the cell. (A code blue is an emergency call sign used by prison staff to alert their colleagues, including healthcare staff, of a medical emergency which involves someone with

breathing difficulties.) The control room Daily Log records that the code blue was called at 8.04am. An officer said that he was instructed by the SO to call for emergency medical assistance by calling a code blue. Another officer said that this officer also ran to tell a nurse of the emergency.

87. The SO and a number of other officers left the office to attend to the man. On arriving at the cell, the officers entered. On re-entering Officer E removed the plastic bag from his head and cut a black lace from around his neck with an anti-ligature knife. (Anti-ligature knives, also known as 'fish knives' or 'cut down tools', are specially designed to cut ligatures.) Officer E and another of the responding officers both checked for a pulse but could find no trace. The SO said that the man was blue in colour and it was his impression that he had already died.

88. The emergency response nurse on duty that day was carrying out his morning duties when he received an emergency radio code blue to attend an incident on the IDTS unit. He said that it took him about two minutes to reach the unit, by which time the emergency response bag had already been delivered to the cell. (The emergency response bag contains various first aid equipment including resuscitation equipment, oxygen and a defibrillator.) The nurse checked for signs of life but could find none and resuscitation was not attempted. He told my investigator:

> "… I checked for any signs of life. His pupils were fixed and dilated, there was no pulse and then unfortunately he wasn't breathing and in those instances where there are no signs of life we do not do the cardio pulmonary resuscitation [CPR]…"

89. According to the control room daily log, an emergency ambulance was called at 8.10am. Early response paramedics arrived at 8.20am followed by an ambulance at 8.24am. The man was pronounced dead at 8.35am.

90. All staff involved in the discovery of the man were invited to a hot debrief. (A hot debrief is a meeting to give staff the opportunity to share their feelings following involvement in a traumatic incident.) Officers told the investigator that they found it helpful to go through what had happened and that the support from the prison's care and welfare team had been good. All prisoners on open ACCT documents were reviewed and support was offered to other prisoners on the unit. Humberside police attended and confirmed that there were no suspicious circumstances surrounding the death.

Family liaison

91. At 10.00am, the Family Liaison Officer (FLO) contacted the Duty Governor at HMP Liverpool, the nearest prison to where the man's mother lived in North Wales. She requested that a representative from the prison break the news of his death to his mother, his designated next of kin, on behalf of Hull. Staff from the prison visited her, and as she was not in at the time, waited for three hours outside of her house. Eventually, they asked North Wales Police to assist in finding her and breaking the news of his death. Later that day North Wales

Police made contact with her, informing her of her son's death and providing her with the contact details of Hull prison.

92. At 6.35pm that evening, the man's mother phoned Hull prison and spoke to someone in the prison's control room. She was asked to ring back the following day in order to speak with a governor. At about 8.30am the following day, she called the prison and spoke to another governor who offered the prison's condolences. The governor provided her with the first governor's contact details. Later that day, the governor rang her and several visits were subsequently made by prison staff to meet with members of the family in Wales and Grimsby. Assistance with some of the funeral expenses was offered by the prison.

Post Mortem and Toxicology

93. A post mortem was conducted. Toxicology results revealed that the man had levels of methadone in his blood which were within therapeutic range, reflecting the dose of methadone that he had been prescribed. The pathologist concluded that the cause of death was likely to have been as a consequence of suffocation by a plastic bag and compression to the neck.

ISSUES

Clinical Care

94. A clinical reviewer was appointed as the clinical reviewer by the local PCT. The clinical review examines the medical care the man received in custody and the clinical reviewer concludes that his general health was managed appropriately. He also reports that there was a good standard of record keeping, and that there was evidence of planned care.

95. In his review, he considers other aspects of the clinical care that the man received while at Hull, including his drug detoxification and the management of his mental health. The clinical reviewer's findings have been incorporated into the broader consideration of issues.

The assessment and management of risk in reception

96. When he was first arrested, the man told police that he had tried to kill himself within the previous two weeks and he had deliberately injured himself in a van. He was therefore placed under constant supervision by police and his risk factors recorded on the PER. Court staff noticed his "bizarre" behaviour, raised a Suicide and Self Harm Warning form and updated the PER with their observations. Again, he was assessed as high risk and made subject to constant supervision until his arrival at prison at 6.35pm, about an hour after his departure from Magistrates' Court.

97. When he got to reception, the man was placed in one of the two immediate holding cells. From their position at the reception desk staff did not have clear sight into the cell which he shared with the other prisoners arriving that day. He was no longer under constant supervision. Three quarters of an hour later, he was seen by an officer who signed to confirm receipt of both the Suicide Self Harm Warning form and the PER Form. The investigator asked the reception senior officer if prisoners on Suicide Self Harm Warning Forms were treated any differently on arrival in reception. He said they were treated the same unless it was evident, when coming off of the prison van, that they were in distress or that there was a problem. In such cases, they would be taken to one side. The SO told the investigators that he:

> "… was never told at any point he [the man] was on constant watch. I'll tell you that sir, because I wouldn't have put him in a holding [cell] by himself I would have sat him on the chairs [outside of the cell]. That's a very rare thing we get constant watches."

98. Court staff had telephoned Hull's reception in advance to warn them of the man's risk. The SO took the call, but said to the investigation team:

> "… at no point did I get told he was on a constant obs [observation] because alarm bells would be ringing that's the last thing you want put somebody in the cell, you know and they are not very nice sort of places to be sat …"

The SO said that escorting officers had never alerted him to a prisoner on constant observation when they arrived in reception. He said:

> "And to be fair I'd rather they did because if they are coming through on a constant watch the last thing I want is a lad on constant watch stuck in a crowded cell waiting to be processed."

99. Prison Service Order 2700, Suicide Prevention and Self Harm Management, Section 4.5.2 says:

> "The receiving reception staff must then keep the prisoner safe following local protocols relating to the location, supervision and support of potentially at-risk prisoners pending the reception healthcare screen. It is good practice to 'fast-track' an at-risk prisoner to the reception healthcare screen."

100. The court staff telephoned the reception at Hull in advance with their concerns regarding the man and recorded this conversation on the Suicide and Self Harm Warning Form. However, no safeguards were put in place on his arrival, such as 'fast-tracking' he through reception as the PSO suggests. His risk had been communicated by telephone and recorded on his records. It remains the responsibility of staff in reception to satisfy themselves that a prisoner is not at risk of harming themselves as soon as possible after they arrive in prison. We therefore make the following recommendation:

The Governor should ensure that all staff are aware of the need to consider fast-tracking prisoners on their arrival in reception if they have been identified as at risk of self harm.

101. During the investigation, a number of staff reported to the investigators that G4S staff (who provide court and escort services) were recently instructed to open Suicide Self Harm Warning Forms on any prisoner who had self harmed in the previous three months. The investigators were told that there had been a significant increase in the number of Suicide Self Harm Warning Forms opened as a result. During the investigation, the SO described the warning forms as a "regular occurrence". Other reception officers gave the impression that the number of warning forms undermined the importance attached to them in the assessment of risk.

102. It is a matter of concern if Suicide and Self Harm Warning forms are not effectively communicating risk. If Hull staff feel that the Suicide Self Harm Warning Form is being used inappropriately by G4S staff then this is a matter managers should raise directly with G4S.

The Governor should work with G4S staff to ensure that Suicide Self Harm Warning forms are effectively communicating risks of self harm.

Consideration of ACCT by reception officers

103. Both the PER and the Suicide and Self Harm Warning form described the man's risk factors. They also recorded that he had been subject to constant supervision. An officer signed the Suicide Self Harm Warning Form indicating that the man would be kept safe until he went to the healthcare nurse for further screening. She said that at this stage of the process she would not make any consideration as to whether to open an ACCT. The SO had been previously notified of the man's "…demeanour and condition", but did not open an ACCT.

104. Another officer completed the reception interview once the man's warrant and property had been checked. He told the investigation team that he would have gone through the information written on the Suicide Self Harm Warning Form, as well as other accompanying documents:

> "Whatever the information that was written there I would have gone through. But like I said I can't remember exactly everything that I spoke to him about. But when I'm interviewing a prisoner I generally see what is in front of me and how they are at that point …not what they were about an hour ago, two hours ago, three hours ago or 10 minutes ago."

The officer said that the man "… wasn't the person standing in front of me that was written about, that person, two days previous." He added that, "… he didn't give any indication [to] the fact that he wanted to die." As a consequence of his assessment, the officer did not think he was at risk of self harm and did not open an ACCT.

105. The man was seen by three officers, all had access to the Suicide Self Harm Warning Form and PER Form but none, based on the evidence provided, opened ACCT procedures on him. Prison Service Order 2700, Suicide Prevention and Self Harm Management, Section 4.5.2 says:

> "Whilst it is the practice in many establishments for the decision on whether the risk indicated by the Suicide/Self-Harm Warning Form is current to await the reception healthcare screen, there is no bar to other reception staff opening an ACCT Plan immediately upon reception if they think this necessary."

106. Hull's local Suicide and Self Harm Policy, states on page 14 that, "Suicide and self-harm in custody is everyone's responsibility." The policy sates that:

> "An ACCT should be raised in **every** case of: Threats of self harm. Acts of self harm. Information received from outside agencies, stating that the prisoner is at risk of the above … It is the responsibility of the member of staff who received the information or identifies risk, to open the ACCT."

107. According to the Suicide Self Harm Warning Form and PER Form, the man was at risk of harming himself and had recently attempted to kill himself. Hull's own

local guidance requires staff should open an ACCT in these circumstances. However, none of the reception staff opened an ACCT.

The Governor should ensure that reception staff are aware of their responsibility to open an ACCT if there is information that the prisoner has self-harmed or threatened to do so, in accordance with its own Suicide and Self Harm policy.

Sharing of information with healthcare staff

108. Prison Service Order 2700, Suicide Prevention and Self Harm Management, Section 4.5.3 says:

> "Whenever a prisoner arriving in Reception is accompanied by a Suicide/Self-Harm Warning Form, the PER, once seen by the receiving Reception Officer, must be passed with the Suicide/Self-Harm Warning Form to the reception healthcare screener."

109. Nurse A completed the man's first night reception health screen. Officer B said he passed all of the information relating to the man to the nurse, including the Suicide Self Harm Warning Form and PER. The nurse signed the Suicide Self Harm Warning form and indicated that opening an ACCT on the man was not necessary. However, he told the investigation team that he could not recall seeing his PER.

110. It became clear during the investigation that other members of the healthcare team were not aware of the Suicide Self Harm Warning Form. The doctor said that he believed a copy of the Suicide Self Harm Warning Form would have been filed on the hard copy of the clinical record. However, he explained that during consultations he would normally only have access to a prisoner's electronic medical record. The doctor explained that it would be of benefit if such forms could also be scanned onto the electronic medical notes system.

111. Whilst attending court on 14 February, G4S staff opened a second Suicide Self Harm Warning Form on the man. An officer signed the Suicide Self Harm Warning Form before passing the man's documentation to the reception senior officer to check. Any prisoner with a Suicide Self Harm Warning form should be assessed by a reception nurse. There is no evidence to suggest that he was assessed on this occasion and the healthcare section of the form was unsigned. It is imperative that any prisoner returning with such a warning to the prison should be properly assessed by staff.

112. In his clinical review the clinical reviewer reports that:

> "Risk assessment is a major issue and vexing problem. There should be a review of how the information is collated and presented to the health care team. Use of the prison escort report [PER] was not documented on the medical computer system."

113. Staff must have access to all relevant information accompanying prisoners when considering their risk and immediate needs. Therefore, we make the following recommendation:

The Governor and Head of Healthcare should ensure that healthcare staff have access to relevant documentation, including PER Forms and Suicide Self Harm Warning Forms in order that they can carry out a complete assessment of a prisoner's risk, in line with the requirements of the PSO 2700.

Staff awareness of prisoners at risk of self harm

114. Prison Service Order 2700, Suicide Prevention and Self Harm Management, Section 4.5.4 states:

> "Upon receipt of the Suicide/Self-Harm Warning Form and the PER the reception healthcare screener must decide, having spoken to the prisoner and considered all other information available, whether to open an ACCT plan. If the prisoner has self-harmed during the time spent that day (or possibly longer if a new arrestee) under supervision, at court, in transit, or while in police or other custody then the reception healthcare screener must open an ACCT plan."

115. The nurse noted in the man's medical records that he had not previously tried to harm himself. The investigation team asked him if he thought that the comment noted on the Suicide Self Harm Warning Form, about removing the stitches from his head wound was an act of self harm. He said, "Not necessarily, well it's not necessarily an action of self harm, sometime its frustration… ". He added that prisoners would "… behave quite differently in police cells to how they behave with us here". The nurse went on to tell the investigators that the man "… didn't present to me as being of any risk of self-harm at that time".

116. The man's self harm was highlighted on the Suicide Self Harm Warning Form. The PSO reminds staff that self harm "must always be taken seriously", even if the prisoner does not intend to kill himself. In spite of this guidance, the nurse did not consider that him removing stitches from his head was self harm because of his situation at the time. As a result, he did not open an ACCT, in line with the requirements of PSO 2700.

117. In his clinical review, the clinical reviewer concludes that reception staff would benefit from additional training in the identification of self harm risks. The Ombudsman agrees with this finding and we make the following recommendation.

The Governor and Healthcare Manager should ensure that all staff working in reception are fully aware and receive training with regard to the indicators and reasons for self harming by prisoners.

Mental health referral and assessment

118. Unless diagnosed with a severe or enduring mental health illness, prisoners located on the IDTS unit at Hull are not automatically referred to the mental health team for a period of two weeks. (This window of referral has now been reduced to five days.) The Head of the IDTS unit explained to the investigation team that mental health cannot be properly assessed until withdrawal symptoms have been stabilised. However, if prisoners have been under the supervision of, or received treatment from, a psychiatrist in the community, they can be referred to the mental health team at any point.

119. In his clinical review, the clinical reviewer notes that it was not recorded if a report was requested from the NHS primary care teams about any relevant past psychiatric history relating to the man. However, having made a request to his GP, the clinical reviewer received several hundred pages of documentation relating to him and his considerable contact with mental health services in the community. The clinical reviewer reports that much of this information was not available to the prison care facility during his admission to Hull.

120. The prison doctor told the investigators that the man did not have a severe mental illness in his view. In his clinical review, the clinical reviewer finds no evidence in the prison medical records that he had any serious mental health issues. He reports that:

> "No in depth assessment of his mental health is recorded. From the records available he did not present any formal symptoms. No record of impulsivity indicating the likelihood of serious harm is recorded. The records show the medical team did try to get information from past immediate health care sources about his medication after he had been seen by the medical staff."

121. However, he goes on to say:

> "… if all this detailed information had been available to the teams then a referral to a specialist psychiatric team would have been clearly necessary to obtain the specialised assessment. A more complete assessment would have been available and action taken including more careful monitoring in the correct environment."

122. PSO 3050, Continuity of Healthcare for Prisoners, Chapter 2, Reception, Section 2.1 says:

> "Efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with."

123. As the clinical reviewer suggests, if the man's community health records were available to healthcare staff, a mental health referral may have been made. It is possible that intervention by mental health staff may have provided him with additional support while he was in custody. He concludes that consideration

should be given to retrieve medical information from a prisoner's GP when, "there is a suspicion of challenging behaviour and problems". We therefore recommend that:

The Head of Healthcare should ensure that procedures are in place for the timely retrieval of medical records from the community.

IDTS treatment

124. The man had a history of drug abuse and tested positive for methadone. IDTS ensures that prisoners withdrawing from opiates are assessed by a doctor and prescribed treatment from their first evening in custody. Unfortunately, the IDTS doctor did not report for work that evening, so he could not be assessed until the following morning.

125. The investigator asked the prison doctor if not seeing a doctor that first night would have any impact on the man's treatment. He said, "…as long as he wasn't showing obviously withdrawals from methadone, from opiates, then it would be reasonable to monitor him…" He told the investigators that the IDTS nurse could administer medication which would have assisted in the relief of any symptoms of withdrawal in the absence of a doctor.

126. In his clinical review the clinical reviewer reported that although,

> "No doctor was available on the evening of reception. From the information given by the IDTS team the man was unlikely to have been re-started on methadone the first night if the duty doctor had been present or at least only a small dose of methadone perhaps 10mls six hourly would have been prescribed. The wing nurses are able to give symptomatic treatment but not controlled drugs."

127. The IDTS Team Leader said that it was rare that there would not be an IDTS doctor on duty. In his review, the clinical reviewer concludes that although the unplanned absence of the detoxification doctor meant the man was not assessed and prescribed methadone, he was "… of the opinion this did not affect materially his standard of care".

128. Overall, the clinical reviewer reports that the man's medication and treatment for substance misuse was "… well within the norm for this condition which relies on regular review of subjective and objective features…". The clinical reviewer concludes that IDTS policies were clear and appeared to be followed correctly in the use of opiate substitution. He concluded that the level of care was "… more than satisfactory".

Non completion of roll count and departure of night shift officers

129. Officer C told the investigation team that he completed the early morning roll check of the IDTS unit at about 5.30am. He explained that to carry out a roll check, he looks through every observation panel on the unit. Although he cannot specifically remember seeing the man that morning, He said that he

would have recalled him being under the bed, and would have tried to get a response from him. Therefore, he did not think it was likely he was under his bed at the time of the morning roll count.

130. The officer left the IDTS unit at 6.30am, leaving Officer D to cover two wings. The investigators were told that it was accepted practice that the two night officers leave once one of the officers on the early shift arrives. He explained that both officers leave together as only one of them carries a key to exit the wing.

131. However, realising that an officer had not arrived for his early shift on the IDTS unit, Officer D telephoned the roll through for both wings. He told the investigation team that he had not carried out a check of the roll on either H wing or the IDTS unit, but relied on the count taken by the night officers.

132. Although it may be accepted practice at Hull for officers to leave earlier than their official shift ends, it is of concern that Officer D was effectively left to look after both H wing and the IDTS unit, for which he was not fully responsible. He told the investigators that he did not complete a roll count of H wing as another officer had only informed him 15 or 20 minutes previously that the roll was correct. Because of this and because the relieving officer for the IDTS unit had not arrived, he phoned the rolls through based on the counts completed by the night officers. We do not apportion responsibility to any one member of staff that morning, the actions of one leading to the actions of another. However, we are sufficiently concerned to conclude that the safety of both wings may have been compromised during this period of handover from one shift to another.

133. The time of the man's death is unknown. Therefore, it is not possible to conclude that the outcome in this case would have been different for him, had Officer D carried out the roll checks. However, it is for the Governor to satisfy himself that the safety and care of prisoners and the security of the wing is not being compromised as a consequence of handover practices between shifts. I therefore make the following recommendation:

The Governor should ensure that the care, safety and security of prisoners is not compromised by the practice of staff leaving duty before their official finishing times.

Raising the alarm

134. Hull's local policy document, Suicide and Self Harm Policy, page 55, clearly outlines detailed actions to be taken by staff when discovering a prisoner who has carried out an act of self harm. It states that staff should:

> "Summon help and request medical assistance via telephone or UHF [ultra high frequency] radio … where there is a disruption to the airways a Code Blue should be transmitted… Enter the cell as soon as possible … Before entering the cell, staff must inform Comms or Oscar 1 of the incident, using the code red or code blue protocol. They must wait for assistance form other staff if they think this is necessary."

135. In spite of the policy, Officer E left the man's cell to raise the alarm. When asked by the investigators why he left the cell to seek assistance, he said that he was concerned that the radio system might have been affected by the start of the shift. He said that as the office was only about 50 metres away and he thought he would get assistance from staff more quickly. He said he did not remove the bag from the man's head to check his vital signs because he believed him to be already dead from his appearance. It was his view that rigor mortis had already set in.

136. It is appreciated that the officer believed the man to be dead when he found him, and clearly recalled that rigor mortis was present. He also acted with the best of intentions, to summon help as quickly as possible. However, it is of concern that he did not immediately remove the bag from the man's head in order to check his vital signs. Accordingly, we make the following recommendation:

The Governor should ensure that all staff are aware of the emergency actions to be followed in the event of self harm, in line with Hull's local policy on Suicide and Self Harm.

Delay in calling of an ambulance

137. The man was discovered at 8.00am, but an ambulance was not called until 8.10am, ten minutes later. The investigation team were unable to establish which member of staff made a request for the emergency services to be called. In his clinical review, the clinical reviewer highlights a training need with regard to this delay. He noted that it was "… unclear whose responsibility it is to call an ambulance after a code blue".

138. It is essential that ambulances are called immediately to emergency situations such as this. Any delay can have a significant impact on a person's chances of survival. Hull has a clear policy for calling an ambulance. Hull's local policy document, Suicide and Self Harm Policy, page 55, paragraph 6 says:

> "The decision for authorising an ambulance/paramedic to attend an incident can be made by any member of staff attending the scene via the Control Room. It should not be, for example, a requirement in every case for a member of the Healthcare Team to attend the scene before the Emergency Services are called. However, a subsequent 999 call to the ambulance service should be made to cancel the response if, after the original 999 call has been made, a member of the Healthcare Team arrive with the patient and deem that an emergency ambulance response is not required."

139. This protocol does not appear to have been followed and we therefore make the following recommendation:

The Governor should ensure that all staff are aware of the importance of

calling an ambulance promptly.

Family Liaison

Contacting the family after the man's death

140. The man's mother and next of kin lived in North Wales. In accordance with procedure, Hull asked someone from Liverpool prison to break the news of his death on their behalf. Prison staff attempted to make contact on the morning of 2 March. Although from the family liaison log it is not clear why they could not do so, after three hours of waiting at her home they asked for the assistance of North Wales Police to break the news of his death. Eventually, the police contacted the man's mother and passed on the contact details of Hull prison. At 6.35pm that evening, she telephoned the prison for further information, but was told to call back the following day.

141. It is to be regretted that no one at Hull was able to offer any information to the man's mother that evening or were able to give the immediate contact details of the FLO in order that she could make contact. The family said how they had been told that he had hanged himself and were only told by police, later, that he had put a bag over his head. The lack of contact with the family after his death may have led to this misunderstanding. This sequence of events is unfortunate and could only have added to the family's distress at this difficult time. As a consequence we make the following recommendation.

The Governor should ensure that the prison's Family Liaison Officer is available to take calls from family members, including during out of hours, immediately after a death in custody.

Contribution by HMP Hull to the man's funeral

142. Prison Service Order 2710, Follow up to Deaths in Custody, requires that the Governor of a prison should, "offer to pay reasonable funeral expenses", to the family of the deceased. Further guidance with regard to this matter is provided in 'Liaison with Bereaved Families Following a Death in Custody Guidance Supplementary to Chapter 4 of PSO 2710 Follow up to Deaths in Custody'. Section 4.29 of the guidance says:

> "Offer to pay reasonable funeral expenses or, if the family want particularly expensive arrangements, offer a contribution. £3000 is the sort of figure considered reasonable in 2005-06 but do not quibble over small sums. This offer should be made irrespective of whether the family is entitled to claim a grant from the Social Fund. The prison should not normally pay for ancillary items such as clothing for those attending the funeral but exercise discretion in the individual circumstances of the case. Be careful not to mislead the family or increase their expectations beyond what is being offered. Arrange to make payments direct to the funeral directors. If there are substantial additional costs, for example, the cost of transporting the body abroad,

refer to the Area Manager or Safer Custody Group for advice."

143. Initially, Hull authorised a payment of £2,293.00 as a contribution to the costs of the funeral as the "reasonable" amount as outlined in PSO 2710. This covered professional funeral services, embalming fee, a hearse and limousine, care of the deceased and coffin.

144. However, the total cost of the funeral was £3007, excluding a sum of £100 for obituaries. As a consequence the prison did not meet these additional costs amounting to £714. These included the cremation, urn, internment of ashes and the cost of clergy to officiate, which this office also regarded as reasonable funeral expenses.

145. It is the experience of this office, in dealing with many different establishments from across the prison estate that funeral costs paid subsequent to a death in custody are either met in full or a contribution to the recommended limit of £3000 is paid. Indeed the Prison Service's own guidance states that £3000 was considered reasonable in 2005-06.

146. We are pleased to report that as a consequence of the advanced disclosure of this report to the National Offender Management Service, Hull prison agreed to the payment of an additional £800 to the family with regard to meeting the additional costs of his funeral.

CONCLUSION

147. Whilst in police and court custody, the man was considered high risk of harming himself and as a consequence he was placed on constant supervision. Despite clear information on his records that he was at risk of self harm, he was not placed on ACCT procedures.

148. The man's substance misuse was addressed and he was on an effective detoxification regime. However, he was not referred for a mental health assessment, and his community records were not retrieved to confirm the significant interaction he had with psychiatric services.

149. This report into the man's death has highlighted a number of significant concerns about the way prisoners who are at risk of suicide and self harm are assessed during their reception into Hull. Despite ample warning, staff did not open ACCT procedures on him when he arrived at the prison, which is most concerning. We appreciate the time elapsed between his reception and his death, however, the early identification of risk may have enabled more support to have been offered, including referrals to the mental health team, during his time in custody. We also conclude that more could have been done with regard to Hull's approach to family liaison.

RECOMMENDATIONS

1. The Governor should ensure that all staff are aware of the need to consider fast-tracking prisoners on their arrival in reception if they have been identified as at risk of self harm.

   Accepted – *All reception managers have been instructed and staff are fully aware of the need to fast track prisoners who have been identified as at risk of self harm on initial reception.*

2. The Governor should work with G4S staff to ensure that Suicide Self Harm Warning forms are effectively communicating risks of self harm.

   Accepted – *Any prisoner who is identified as at risk of self harm prior to reception into HMP Hull have a "at risk warning form" raised by the escort provider, this document is passed to the reception Senior Office on arrival.*

3. The Governor should ensure that reception staff are aware of their responsibility to open an ACCT if there is information that the prisoner has self-harmed or threatened to do so, in accordance with its own Suicide and Self Harm policy.

   Accepted – *All reception managers and staff have been advised to carry out their duties / responsibilities in line with the establishments Suicide Self Harm Policy.*

4. The Governor and Head of Healthcare should ensure that healthcare staff have access to relevant documentation, including PER Forms and Suicide Self Harm Warning Forms in order that they can carry out a complete assessment of a prisoner's risk, in line with the requirements of the PSO 2700.

   Accepted – *All relevant documentation to be provided to the Healthcare Practitioner in order to allow a full and complete assessment to be carried out in line with PSO 2700.*

5. The Governor and Healthcare Manager should ensure that all staff working in reception are fully aware and receive training with regard to the indicators and reasons for self harming by prisoners.

   Accepted – *All staff to undertake suicide and self harm awareness training.*

6. The Head of Healthcare should ensure that procedures are in place for the timely retrieval of medical records from the community.

   Accepted – *Protocol/system to be implemented to ensure full compliance.*

7. The Governor should ensure that the care, safety and security of prisoners is not compromised by the practice of staff leaving duty before their official finishing times.

   Accepted – *All staff are to remain on duty until such time their shift ends or they*

are relieved by a nominated relief.

8. The Governor should ensure that all staff are aware of the emergency actions to be followed in the event of self harm, in line with Hull's local policy on Suicide and Self Harm.

   Accepted – *Notice to staff to be published and placed on permanent display in all areas outlining the "Emergency Actions" to be followed in the event of an act of self harm.*

9. The Governor should ensure that all staff are aware of the importance of calling an ambulance promptly.

   Accepted – *Protocol published and in place.*

10. The Governor should ensure that the prison's Family Liaison Officer is available to take calls from family members, including during out of hours, immediately after a death in custody.

    Accepted – *All operational managers to ensure family liaison officers are available to take calls from family members. All FLOs briefed, unique mobile telephone number passed to family members calls to be taken up to 22:00hrs during early stages of incident.*