PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Manchester in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is a report into the circumstances surrounding the death of a man, a prisoner at HMP Manchester in January 2012. He was 46 years old and was found hanging in his cell. I offer my condolences to those affected by his death.

An investigator conducted the investigation. The local Primary Care Trust (PCT) commissioned a clinical review into the standard of healthcare the man received in custody which was carried out by a clinical reviewer. Manchester prison co-operated fully with the investigation.

The man had been in custody since May 2010 and transferred to Manchester six months later. Throughout his imprisonment he was considered to be at high risk of suicide or self-harm and was monitored under suicide prevention and self-harm management procedures. He spent a long period as an inpatient in the healthcare wing at Manchester, often being supervised constantly because his risk was regarded as very high. When his ability to cope appeared to improve, he moved to a residential wing and began employment in prison. In the weeks before 23 January 2012, he was considered to be coping well and consideration had even been given to ending the monitoring procedures.

In January, staff found the man in his cell with a ligature around his neck. Medical assistance was sought but attempts at resuscitation were unsuccessful. His death came at a time when he was considered by those caring for him to be progressing and positive about the future.

I am satisfied that the man's risk of suicide and self-harm was generally well managed in prison. When he was regarded as very high risk he was appropriately supervised and managed. Some good efforts were made to help him keep in contact with his partner and a family member was brought in to the prison to help support him. At the time of his death it appears to have been reasonable for prison staff to have concluded he was no longer such a high risk. The risk that someone in his position might choose to take their own life can never be eliminated and, while the investigation has identified some room for procedural improvements, overall I consider that staff at Manchester did what they could to protect him.

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 **October 2012**

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SUMMARY

1. The man was remanded into prison custody at Magistrates' Court on 19 May 2010. He had been extradited from Spain to face charges in relation to serious sexual offences. Before his arrival into prison custody, the police told him that his two young children had died and his partner had been arrested in Spain in connection with their deaths. There was a high level of media interest in his case.

2. Immediately on his remand to HMP Durham, the man was monitored under suicide and self-harm prevention procedures. He was clear about his intention to take his own life and, as a result, he was placed on the highest level of supervision. This continued throughout his time at Durham and when he transferred to Manchester on 25 November 2010.

3. For the majority of his time at Manchester, the man lived on the healthcare inpatient unit, and remained on constant supervision until 14 January 2011. Regular support was given to him by both prison officers and medical staff but, at times, he chose not to engage with them or be involved in attempts to support him. He continued to be open about his intention to kill himself. An identified protective factor for him was his relationship with his partner, but her imprisonment in Spain was also seen as a potential trigger for his self-harm. There were sometimes difficulties in arranging contact between them.

4. After his conviction in December 2010, and sentencing in March 2011, the man appeared to become more positive. He moved to a residential unit and settled well. In November 2011, he harmed himself by cutting his arms and went back to the inpatient unit on healthcare for two weeks. Afterwards, he settled back into the wing and returned to work. He was hoping to move to HMP Wakefield. At his last suicide prevention review on 12 January 2012, the staff present were hopeful about ending the monitoring.

5. Towards the end of January, staff found the man hanging in his cell. Despite attempts by prison medical staff and paramedics to try and revive him, he did not respond and, at 7.00pm, the prison doctor pronounced him dead. Because of the distance from the prison, arrangements were made for the police to notify his sister and the prison family liaison contacted her the next day.

6. The clinical review concluded that all the decisions made about the man's medical care were appropriate. We similarly conclude that he was, in the main, well cared for and managed. However, we have made four recommendations about the need to ensure that suicide and self-harm documents are completed accurately and that staff are adequately trained to fulfil the various roles in the process. The Prison Service has accepted all four of our recommendations.

THE INVESTIGATION PROCESS

7. An investigator was appointed to carry out the investigation. He contacted HMP Manchester and arranged for the man's prison and medical records to be made available. He visited Manchester on 15 February and spoke to the Governor and staff from the safer custody team. He also visited E wing and spoke briefly with the staff on duty. Notices were issued to staff and prisoners to inform them of the investigation and invite them to provide relevant information about the death. There were no responses.

8. The local PCT commissioned a review of the medical care given to the man while in custody. A clinical reviewer completed this review on their behalf.

9. One of our family liaison officers (FLO) contacted the man's sister, his nominated next of kin on 14 February, to explain the investigation. She was concerned about a letter her brother had received shortly before his death, and other correspondence, which had been taken by the police following his death. The FLO and the investigator visited her on 21 March to discuss her concerns in more depth. She expressed concerns about a number of matters such as her brother's appeal. She also discussed how contact with his partner had been an important factor in her brother's well-being while in custody. The family have provided a response to the draft report and this is summarised in the report.

10. The investigator informed HM Coroner of the investigation and asked for any relevant documentation removed by the police to be shared. The Coroner agreed and sent him a copy of a letter received by the man shortly before his death. He also requested a copy of the post mortem and toxicology reports.

11. On 2, 3 and 4 April, the investigator returned to Manchester to conduct interviews with prison staff, assisted on the latter dates by an Assistant Ombudsman. Following the interviews, both verbal and written feedback was given to the Governor.

HMP MANCHESTER

12. HMP Manchester is a high security prison near the centre of the city. In addition to its function as a category A prison, Manchester also operates as a local prison, serving the courts of the Greater Manchester area. It holds up to 1,269 adult male remand, convicted and sentenced prisoners.

13. NHS Manchester commissions healthcare at HMP Manchester. The prison provides 24-hour nursing care and the healthcare centre includes an in-patient unit. Primary care services include access to a range of in-house and visiting specialist clinics. The healthcare team is nurse led and there is a full-time doctor supported by a part-time doctor and locums. Qualified general and mental health nurses and healthcare assistants make up the permanent healthcare team. Specialists in mental health, dental care, opticians and other areas of secondary care visit the prison on a regular basis.

Her Majesty's Inspectorate of Prisons

14. HM Inspectorate of Prisons (HMIP) last carried out an inspection of Manchester in September 2011. In the introduction to the inspection, the Chief Inspector referred to self-inflicted deaths at the prison, said:

> '…Our most serious concern about the prison was the high level of self-inflicted deaths. This had been the case for many years and was higher than most other prisons. There had been seven self-inflicted deaths since the beginning of 2009, five of them since our last inspection in July 2009. There was a degree of fatalism in the prison's response to this – that was the way things were in Manchester I was told. Arrangements for caring for prisoners at risk of self-harm or suicide were not poor but there was room for improvement. The prison was not active enough in ensuring lessons were learnt from previous cases (both at Manchester and elsewhere) and ensuring they were consistently applied. As a matter of urgency, the prison needed to apply the same vigour and determination to this issue as it had to others. Its own health department's approach to serious incidents, near misses and deaths in custody generally was good practice and an obvious starting point for tackling the specific issue of self-inflicted deaths…'

Independent Monitoring Board (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board (IMB). Members of the Board are volunteers from the local community who monitor day-to-day life in the prison to help ensure proper standards of care and decency. The most recent annual report by Manchester IMB was published in February 2011. The Board said:

> '…The prison makes a big commitment to safer custody and there are several strategies in place to make the prison a safer place. Examples are Violence Reduction, Anti Bullying, Suicide Prevention and Self

Harm Management and Anti Social Behaviour…There is a Safer Prisons Team…a full time Safer Custody Manager and a deputy in post. Meetings are held for all these strategies each month. Board members regularly attend these meetings as observers. Outside bodies such as Samaritans are also involved. Prisoner representatives such as wing Listeners also take part.'

Previous deaths at Manchester

16. Since 2009, there have been seven self-inflicted deaths at Manchester before the man. Issues and recommendations from these earlier investigations are not repeated in this report.

Assessment, Care in Custody and Teamwork (ACCT)

17. Assessment, Care in Custody and Teamwork (ACCT) is the process used in prisons to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT monitoring, the prisoner is subject to regular case reviews that will direct supervisions/conversations to be carried out at intervals determined by their perceived level of risk. The supervisions continue during the day and the night. The highest level, 'constant supervision', is where a prisoner is supervised by a designated member of staff on a one to one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly. The next highest, 'intermittent observations', indicates that a prisoner is observed at least five times per hour. Observations can be reduced as required.

Cardiopulmonary resuscitation (CPR)

18. CPR is an emergency procedure which is performed in an effort to manually preserve intact brain function until further measures are taken to restore blood circulation and breathing in a person in cardiac arrest.

Automated External Defibrillator (AED)

19. Defibrillators are portable units, used in life-threatening emergencies to analyse heart rhythm and advise whether a controlled electric shock is required. They are designed to be easy to use by non-medical persons, who require little training to operate them correctly. Trained health professionals, are able to diagnose and treat a wider range of problems with manual or semi-automatic units. For this reason, paramedics at an emergency usually replace the AED with their own equipment.

KEY EVENTS

20. The man was remanded into prison custody at Magistrates' Court on 19 May 2010. He had been extradited from Spain, where he had been held in prison for ten days, to face charges in relation to serious sexual offences. Before his arrival into prison custody in the UK, the police told him that his two young children had died and his partner had been arrested in Spain in connection with their deaths.

21. As a result of the bad news given to the man, staff at the court completed a form to indicate the possibility that he might harm himself and this was sent with him to HMP Durham. Due to media reporting, on his arrival at Durham, staff were already aware of his circumstances. They immediately began monitoring him under the ACCT suicide and self-harm procedures.

22. A nurse completed an initial health screen with him, as part of the routine reception process, in which she recorded his previous medical history and existing physical health concerns. During the health screen, he raised concerns about his physical health, and told her that he was asthmatic and required an inhaler. He also described previous attempts to take his own life while he was in custody in Spain. She referred him for assessment by the Mental Health In-Reach Team (MHIRT) at the prison and arranged for him to be located in the healthcare centre, so that his mental well-being could be observed.

23. Once reception procedures were complete, the man was taken to the healthcare wing, where an ACCT case review was held. A multidisciplinary review panel discussed with him the events that had preceded his arrival at Durham, and his previous self-harm in Spain. He said that he had intended to take his own life in Spain and regretted waking up. He told the panel that he continued to have thoughts of ending his life, and had considered doing so by not eating or drinking. He referred to past episodes of depression and hearing voices, for which he had never received treatment. When discussing supportive factors, he said that he would like to attend the chapel to light a candle for his children and to have some form of contact with his partner, if possible. The review panel concluded that his risk of harming himself was high and that he should be constantly supervised.

24. The following day, a community psychiatric nurse (CPN) carried out a mental health assessment with him. He spoke of his frustration and anger at not being able to contact his partner in Spain, and his disappointment that his suicide attempt in Spain had failed. She recorded that he was tearful and distressed throughout the assessment. When asked about thoughts of harming himself, he described himself as numb and frustrated. He told her that he 'wanted things to be over'. When asked to expand on the statement he said that he was trying to plan how he could die but, as he was on constant supervision, his only option was to stop eating. She concluded that there was no evidence that he was suffering from psychosis or thought disorder, but he was clearly in shock and the news of his children's deaths had not sunk in.

25. The CPN recorded that she had spoken to the prison chaplain about the man, who agreed to spend some time with him. She also asked the safer custody team about the possibility of them arranging contact between him and his partner.

26. Later that day, a prison GP assessed him. The doctor recorded that the man described to him that he had a history of intermittent loose stools with blood every few days for the past two years. He referred him under the fast track system for suspected colorectal cancer and arranged for a specialist from the local hospital to assess him during his prison clinic on 26 May.

27. The specialist concluded that there was nothing abnormal. Nevertheless, he booked a colonoscopy (examination of the bowel). Before the colonoscopy, the man had to take medication to clear his bowels. However, he declined as he felt that he would not have the privacy he required due to constant supervision. He was moved temporarily to another cell, which would enable him to use the toilet as required, but still ensure that his safety was maintained. He was still not happy with these arrangements, and signed a medical disclaimer to say that he did not wish to have the procedure carried out.

28. Constant supervision continued and daily multidisciplinary reviews took place. As the man continued to state his intention to take his own life, the review panels were unable to reduce the frequency of the supervisions. As part of the ACCT process, staff had completed a Caremap. This highlighted the concerns considered by the review panel to be of most importance to him and how they would be addressed

29. To achieve one of the objectives listed on the Caremap, the prison contacted the Foreign and Commonwealth Office to help facilitate some contact between the man and his partner. As a result, he was able to have telephone conversations with her from Durham, which helped improve his outlook. Unfortunately, the logistics of arranging these calls meant that they were irregular. When they did not take place, he became distressed, frustrated and concerned for his partner's safety and mistrustful of staff.

30. The press interest in the man's case and reporting in national newspapers also meant that he was subjected to abuse and threats from other prisoners. On 31 May, he was assaulted by another prisoner. He was treated at the local hospital for an injury to his head from a pool cue. The prisoner who assaulted him was dealt with under the prison's internal disciplinary procedures.

31. The safer custody team told the man during an ACCT review that they had been contacted by his sister, with whom he had not had contact for some time and they thought this would provide more support for him. He was content for safer custody staff to speak to her about his care.

32. Daily reviews involving staff from various departments took place to try to manage his care while he was at Durham. He continued to refer to the contact with his partner as being the most important thing to him, and without it he said he had little else to live for. When he was asked about current thoughts of self-

harm, he continued to state his fixed intention to take his own life. He made active attempts to do so. On one occasion he removed the laces from his shoes intending to hang himself, and on another he was found to be storing medication with the aim of taking an overdose. In view of all these factors, the prison continued to monitor him constantly. Throughout his stay at Durham he was regarded as at high risk of attempting suicide.

33. The man was assessed by a consultant forensic psychiatrist in June and July 2010. The psychiatrist concluded that he was going through 'an adjustment reaction and abnormal grief reaction' which he considered to be understandable in the circumstances. He advised that it was crucially important to review his mental state after certain events such as when he received letters from his partner, attending court, awareness of media interest and other significant changes in his social circumstances on remand. The psychiatrist also believed there was an element of manipulation in his actions. Although several subsequent appointments were made over the next three months, he refused to see the psychiatrist after July. He also refused to participate in any ACCT reviews during that period.

34. To facilitate his court case, the man transferred from Durham to HMP Manchester on 25 November 2010. A nurse from Durham was part of the escort, and provided a full handover of his care to nursing staff at Manchester. He was located in the prison's inpatient unit and constant supervision continued. A nurse was allocated as his named nurse and spoke with him when he arrived at the prison. At interview, she said that, as his named nurse, she spent a lot of time with him. From their conversations, it was apparent that he had felt frustrated at Durham as he could not progress and was unhappy being on constant supervision, as he had no privacy. He told her that he had not got on with staff at Durham, felt that he had been victimised and had been assaulted by another prisoner.

35. An ACCT case review was led by healthcare staff with the man on 25 November the day he arrived from Durham. It was chaired by a senior nurse and his named nurse, together with staff from the prison's safer custody team. They discussed his past and current thoughts of self-harm. He told them that in the past when he had told staff of his thoughts of self-harm, he had personal items taken from him. The senior nurse explained that the role of the staff was to keep him safe, and they had a duty of care to him. If staff felt that he could harm himself with items he had in possession, then these would be removed. He again spoke of being assaulted while at Durham, and the senior nurse reassured him that the healthcare unit was small and staff closely monitored association and exercise periods. The review concluded that his level of risk should remain as 'high.' The issues on the Caremap, such as maintaining contact with his partner were reviewed and re-written, indicating how these could be addressed while he was at Manchester.

36. The man remained on constant supervision at Manchester until 14 January 2011. While he was subject to constant levels of supervision, case reviews took place daily. These were attended by nursing staff, as well as members of the safer custody team, chaplaincy and on occasions mental health staff. A

senior nurse was present at nearly all the reviews while he remained in the healthcare unit and chaired the reviews.

37. The senior nurse explained to the investigator that when the man first arrived at Manchester he was concerned about being constantly supervised and considered it an invasion of his privacy. They explained that as staff at Manchester knew little about him it would be unwise and unsafe to reduce his level of supervision. It was also apparent to the investigator, from the interview, that the high profile of his case, and the media attention it attracted added to the reluctance of staff to reduce the level of supervision too soon. She said that he was told that he needed to work with staff, and a level of trust needed to be established on both sides. His trial was starting in December, and he was still concerned about the welfare of his partner and contact with her. These concerns were seen by the review panel as additional triggers that could increase his risk of self-harm.

38. The nurse said that one of the problems faced by the ACCT review panels was that they believed the man was not always as honest as he could be about his intentions to self-harm. While at Manchester, he often chose not to attend reviews. Her view was that he would attend if he felt his needs were going to be met. If not, or persons were present that he did not like, he would decline and could become quite agitated. During all reviews he was asked about thoughts of self-harm or suicide. She said that when asked this question, he would say that his views on death were different to everyone else's and he had no fear of dying. When pressed on this he said that he thought his time on earth was only part of life, and his life would only start properly after his death.

39. Despite being subject to constant supervision for a long period, the man was able to engage with other prisoners if he wished, and often attended association and periods of exercise in the open air. The investigator asked the nurse whether she ever felt that the level of supervision had a negative impact on him or his risk of self-harm. She reiterated that on his arrival from Durham the staff had little choice but to continue to manage him on the level of supervision. The factors of most concern to him continued to be contact with his partner and the way he felt that he was being portrayed in the media. However, she said that as the constant supervision continued staff with regular contact with him were concerned about its effect. She said that it reached a point after his court case, where the review panel felt that the channels of communication and his involvement in the ACCT process would cease the longer he remained on constant supervision, as he saw it as a barrier to him moving forward. She said that concerns were also raised about the physical effects, as he had complained of being unable to sleep. Her view was that things needed to progress.

40. The man's trial began on 6 December 2010. ACCT reviews were carried out when he returned from court each day, and he spoke openly about how he felt things were progressing and his hopes of being acquitted. He discussed how he felt the media were preventing him from receiving a fair trial and, at times, became very upset. The trial continued until 15 December, when he was convicted of the offences. He returned to Manchester to await a date for

sentencing. He was concerned that he might return to Durham after sentencing but was told there were no plans to do so.

41. As after all his previous court appearances, an ACCT review took place on 15 December, when he returned. He spoke of his shock at being found guilty. He told the review panel that he had obtained an address for his partner in Spain and intended to write to her and maintain contact. When asked about thoughts or intentions to self-harm, he said that his only plans were to contact his partner and begin to work on appealing against his conviction.

42. In light of his conviction and forthcoming sentencing constant supervision continued. He was assessed on a number of occasions between 15 December and 14 January by visiting psychiatrists. During these assessments, he spoke of continued frustration at being on the highest levels of supervision, including the lack of dignity in a gated cell and about contact with his partner. He also regarded any potential return to Durham as a trigger which would increase his risk of suicide. The psychiatrists indicated that a period of stability without a move would enable him to integrate better.

43. On 13 January, a consultant psychiatrist with the MHIRT reviewed the man. He recorded that he had read the assessments and opinions of other clinicians who had recently seen him. Their assessments concluded that he had no mental illness and that he had become more insightful and appropriate in his plans for the future. They also considered that he should be moved from constant supervision to a safer cell and be supervised intermittently. Safer cells are designed to make the act of suicide or self-harm as difficult as possible. This is achieved chiefly by reducing ligature points. Specialist “anti ligature” furniture and fittings are installed as an integral part of the cell fabric.

44. The man told the psychiatrist that he understood the reasons why constant supervision was necessary when he first arrived into custody. However, he now felt better and more able to cope. He added that situations might arise that would cause a worsening of his condition, such as his sentencing, his partner’s trial in Spain, or if he was bullied. However, he felt the staff at Manchester would help him to cope with these situations. The psychiatrist recorded that he agreed with the views of other clinicians that constant supervision should stop.

45. The following day, an ACCT review was held and all present agreed that constant supervision should end and be replaced with intermittent observations. His level of risk was considered as ‘raised’, a reduction in the level of risk from ‘high’, but indicated that the review team still considered that the man required frequent monitoring. He told the review panel that he was looking forward to the future, despite the fact that he was to be sentenced in March. Protective factors included his contact with his partner through letters which he felt that this provided both of them with support. Nursing staff continued to engage with him daily, and ACCT reviews were generally multidisciplinary. The timing of each subsequent review was discussed at each meeting and held either every 7 or 14 days, but was also influenced by his perceived needs.

46. In an attempt to keep moving forward with the man, the safer custody team had attempted to facilitate regular telephone contact between him and his partner in Spain soon after his arrival at Manchester, in the same way that had been arranged previously at Durham. Later, they also arranged for his sister to be involved in case reviews, so that he had other support, and did not focus solely on his partner.

47. The Deputy Safer Prisons Co-ordinator at Manchester attended the majority of ACCT reviews while the man was on constant supervision. She was also instrumental in arranging telephone contact between him and his partner and arranging his sister's involvement in case reviews. She said that he was very closed during case reviews in his first few months at Manchester, and this made it difficult for them to even consider ending the constant supervision earlier.

48. The Co-ordinator explained that the process of arranging telephone calls between the man and his partner was difficult as they were both in prison. It involved a lot of contact with the Spanish Consulate and Spanish Authorities to make it possible. Initially, the safer custody team liaised with the security department to arrange for him to use an internal telephone for the calls. The investigator was told that this was a concern as Manchester is a high security prison and making these arrangements was not straightforward.

49. She said that the agreement was that a member of staff from the safer custody team would be present and monitor all the calls. This was to provide both security as well as to enable anything said that might be relevant to his well-being to be reported back to ACCT reviews.

50. The safer custody team facilitated the calls for around three months and it was then decided that healthcare staff would take over this role. The Co-ordinator said that when this happened the man began to refuse to make the calls. He said he was unhappy with random members of healthcare staff sitting in on the calls and he did not feel confident speaking to his partner in front of them. Following this, the safer custody team began sitting in on the calls again for the remainder of his time in healthcare. ACCT reviews continued to be held by healthcare staff with attendance by the safer custody team and others.

51. The man was sentenced to 16 years imprisonment at Crown Court on 11 March 2011. On his return from court, an ACCT review was held and he told the review panel that the length of the sentence was what he had expected. When asked about his thoughts of suicide or self-harm, he said that his partner continued to be his protective factor and he had no wish to cause her further distress. He told staff that he was living from day to day, but he felt able to talk to staff if he needed to do so. The review panel agreed that based on the positive review, the level of observation did not need to be increased.

52. On 15 March, the Co-ordinator went to the healthcare unit to facilitate a telephone call between the man and his partner. After the call, the officer had a chat with him and asked him how he was feeling. He told her that the night before he was sentenced had been the closest he had been to taking his own

life at Manchester. He said that he had made a plan and considered the various methods he could use. She was asked what actions she took after this conversation. She said that she spoke to a senior nurse and, because the crisis period that had led to him having these thoughts had passed, it was decided that the level of observations would not be increased. She said that this decision was carefully considered and they were keen to keep moving him forward. They did not want to overreact and restart constant supervision. As he was still living in the healthcare unit, the senior nurse felt that he was already receiving a high level of observation and support from the staff.

53. During an ACCT review on 30 March, the man spoke again of having a couple of low points in recent weeks, one before sentencing and another within the previous seven days. He told the review panel that he had not self-harmed, predominantly due to the type of cell he was in, a safer cell. However, he said that he was presently feeling settled and discussed his plans for the future. These included progressing to a non-safer custody cell with eventual location on a residential unit. It was recorded that he was happy with these plans. The review also discussed the future triggers that he still had to deal with, particularly his partner's forthcoming trial in Spain. He said that once this was over he would be able to look to the future and move on. Despite these potential triggers being identified in the near future, a risk level of 'low' was recorded following this review.

54. Despite the positive attitude recorded during the review on 30 March, the man self-harmed by cutting himself on 5 April. This was the first time that he had harmed himself since arriving at Manchester. An ACCT review should have been held following his self-harm, but it was recorded that he preferred a one to one meeting with a senior nurse, which was recorded in the ACCT document. He also spoke with the Co-ordinator outside of the case review. She said that her concerns were that the review held on 30 March had discussed his progress to a non-safer cell and eventual move to a residential wing, but the record of the review did not reflect that a move was a big concern for him. She explained that while he was realistic that he would eventually move, for the moment he was happy that a move was not imminent. Even though he accepted he would have to move eventually he remained opposed to the idea.

55. When the Co-ordinator spoke to the man, he told her that he had a meeting with a doctor, during which the doctor had spoken about moving him on from healthcare, despite the concerns he had raised on 30 March. He said this was the trigger for his self-harm. Her opinion was that the self-harm was a significant attempt and had been taken very seriously by the staff supporting him. The level of risk noted on the ACCT document was increased from 'low' to 'raised' and his observations increased to at least 5 times per hour. She said that it was felt that to go further and restart constant supervision would have been counterproductive.

56. She explained that the long term plan for him was to stabilise him, reassure him that he would be safe in custody and help him progress through his sentence. He had submitted an appeal against his conviction after he was sentenced. She said that his offender supervisor looked at ways that he could be kept

occupied, without addressing his offending behaviour, because as an appellant it was not appropriate at that time. The offender supervisor considered all options, and his sentence plan was structured accordingly, by including a target for him to get a prison job to keep him occupied.

57. The aim of the safer custody team was also to get the man past the trigger dates that had been identified, such as dates of his children's birthdays, deaths and his arrest, as this was seen as the start of his problems. It was explained to him that he needed to progress to a residential wing and find employment, with the ultimate aim of moving to another prison, such as Wakefield, where he could progress further in his sentence. On the anniversary of his children's deaths, in May, he read library books to help distract him from his thoughts, visited the chapel and spoke to his partner.

58. During May and June, he continued to be supported through the ACCT document and additional support was arranged for significant dates. He sometimes declined to attend ACCT reviews and is recorded as walking out of reviews when any mention of moving out of the healthcare unit was mentioned. On 1 June, it was recorded that he alleged that other prisoners in the healthcare unit were bullying him. During the investigation, a senior nurse was asked about these allegations and said that they were taken seriously and investigated by the prison, but no evidence could be found to support them. There is no written documentation of these investigations. Her view was that it would have been difficult for any bullying to have taken place without staff observing it, due to the frequency of observations and the size of the unit.

59. On 7 June, the man chose to speak with two nurses, rather than a full case review panel. He had begun to isolate himself on the unit and this was discussed with him. He said that he did not feel safe in the healthcare unit any longer and wished to move to a residential wing. He also said that he did not feel that healthcare staff could offer him anything to progress further.

60. In June, he received a letter from his solicitors telling him that a decision had been made by a single judge who had heard his case, to refuse him the right to appeal. The letter was passed straight to him and prison staff were not aware of its content. Despite what would have been negative news for him, staff said that he did not mention this to them. The investigator contacted the solicitors who confirmed the content of the letter. Correspondence records relating to letters received and sent by him were also viewed. These show that he had written to two other firms of solicitors following the letter in June, in an attempt to continue with his appeal, but he never raised concerns about this with prison staff.

61. The next review was held on 23 June, which an officer from E wing, the vulnerable prisoner wing, also attended. During the review, the officer explained to the man the facilities and activities available on the wing. The healthcare staff also explained that his move to a residential wing did not mean that they would stop offering him support if he needed it and that the MHIRT would visit him on the wing. He raised no concerns about the matters discussed. His risk of self-harm was considered to be low at this time. His

level of observations were once an hour while he was in his cell, with a requirement for staff to record at least four quality entries during the day and at night in the ACCT document.

62. The man moved to E wing on 24 June. It was recorded that he settled in well to the regime and he was in a shared cell with another prisoner. The Co-ordinator said that when he moved to E wing the safer custody team were asked to take a step back, to allow him to be less reliant on their support. While they still attended some ACCT reviews, they were not as involved as had been the case when he lived in the healthcare unit. Two officers on E wing were also identified to facilitate the telephone calls between him and his partner.

63. The ACCT reviews on E wing were held every two weeks. Most reviews were not multidisciplinary and had little or no input from staff from outside E wing. Thirteen ACCT reviews were held while the man was on E wing. Only two of these were attended by a member of the MHIRT. Nursing staff who had interacted with him regularly on the inpatient unit and known about his problems provided no input to any ACCT review while he was on E wing.

64. Two senior officers, regular managers on E wing, chaired the reviews. When interviewed, both were asked whether they had been given the necessary training to enable them to be case managers and chair ACCT reviews. Neither had attended such training.

65. The man began working on E wing, firstly in the print shop and later in the laundry. When asked about his feelings during ACCT reviews, he said working helped him cope with prison life. There were still occasions when he disengaged with the ACCT process and refused to attend reviews. One of the contributing factors to this was his frustration at his telephone calls with his partner being ‘messed up’.

66. On one occasion, there had been some problems with a telephone call being arranged. Because of delays, he was unable to talk with his partner for as long as he normally did. He later received a letter from his partner telling him that the Spanish authorities had told her that she could only have a telephone call once a month. He felt that this was due to the previous problem, and blamed the prison staff for this. In September, he only attended one ACCT review in which it was recorded that he would not discuss the situation with his partner with anyone, including safer custody staff, as he felt that the prison was the cause of his problems. ACCT reviews continued to be held on the planned dates. He was asked if he wished to attend throughout October, but declined on each occasion.

67. A SO acted as the case manager for these reviews. He said that although the man declined to attend, he was told that the monitoring would continue and was also asked about his thoughts or intentions of self-harm. The SO said he mixed with other prisoners on the wing and attended work regularly.

68. On 3 November 2011, the man made deep cuts to both his arms and was readmitted to the healthcare unit. A senior nurse chaired a case review with

him when he arrived. During the review, he said that before cutting himself he had made a ligature and attempted to hang himself, but as he began to choke, it frightened him and he removed it. She told the investigator that in previous ACCT reviews he had spoken of methods he would use to harm himself and said that hanging frightened him in case it was not successful. Staff asked what had triggered his actions, as they thought that he had been making progress on the wing. He replied that he had several ongoing issues including a lack of contact with his partner and he had argued with his cellmate the previous evening. She said that he told her that when he had things on his mind, being in a shared cell was difficult for him.

69. The man was located into a safer cell and intermittent observations, five times per hour were put in place. The nurse said that the review panel had discussed constant supervision, but considered it unnecessary. The Co-ordinator spoke to him the following day and asked him about the issues with his cellmate. She told the investigator that he was unable to be specific about any real issues with his cellmate, other than he was unhappy. Her knowledge of him was that he liked to spend time sitting quietly and reading, not watching television, so sharing a cell would have been difficult for him.

70. An ACCT review was held on 8 November, chaired by a senior nurse. Safer custody, mental health and chaplaincy staff attended. The man felt settled, having moved away from E wing where he felt intimidated by his cellmate, but could not expand on the reasons for this. He told the panel that he found it difficult to share a cell and doing so increased his stress and anxiety. The issues with contacting his partner were discussed and he told the panel that he was aware that she did not wish to have telephone conversations at this time, but she was still receiving his letters. A further case review was planned for 10 November, to discuss his future and a possible move to HMP Wakefield. The review panel agreed that the intermittent observations could stop. Staff said that they then engaged with him four times per day and four conversations or observations during the night.

71. The safer custody team were instrumental in arranging for the man's sister to become involved in the planning of his care and the ACCT process. The Co-ordinator explained that the team considered this appropriate, as no other protective factors, other than his partner, had been identified. He confirmed he was content for his sister to be involved.

72. The man's sister attended the review held on 10 November. The Co-ordinator thought that his sister's involvement was beneficial as sometimes he could be quite negative. His sister was able to say things to him which the staff could not. It was also useful as he saw it as having a friend in the reviews, and she was able to reassure him that staff were trying to help. Outside reviews, or when reviews were held that she did not attend, the Co-ordinator contacted her and updated her on the progress or problems that had been discussed.

73. The man remained in the healthcare unit until 17 November when he returned to E wing. Before he moved, an ACCT review was held. He said that while he felt slightly stressed about the move, he had positive plans for the future, which

included returning to work. The review panel advised him to approach staff and alert them to his concerns if he had difficulty coping. In an earlier review, it had been decided that as the trigger for his previous self-harm was sharing a cell, he would be given a single cell, and this would be kept under review.

74. He settled in well on his return to E wing and began working in the workshops again. Wing and safer custody staff held fortnightly ACCT reviews with him, but with no input from healthcare staff. When asked about thoughts or intentions of self-harm, he said that he was learning to deal with his situation. At a review on 28 December, he said that he still experienced the odd bad day, but being in a cell on his own helped, as he coped better.

75. The last ACCT review took place on 12 January 2012. The man's offender supervisor and the Co-ordinator attended and he said that he felt he was 'in a better place' although he was still uncertain to some extent on his suicidal thoughts.

76. The Co-ordinator said that, during that last review, a transfer to Wakefield was also discussed with him. It was explained that this was seen as a progressive move for him, and it was felt that they had exhausted what they could offer him at Manchester. She said that the team believed that they had taken him from being very low, not making eye contact and not engaging when he first arrived at the prison, to living on a standard prison wing, working and reasonably managing his thoughts of self-harm. She said that the only negatives from the review was his frustration at the time it was taking to arrange his transfer, and he feared that he might be forced to share a cell again if this did not happen soon. He was reassured that this would be discussed, should such a decision be made. She said that on the whole the review was positive and focused on the progress he had made.

77. Although the panel did not feel the ACCT should be closed at that review, the Co-ordinator said that they were the closest they had ever been to making that decision. His level of risk was considered to be low and staff were required to evidence their interactions with him at least four times during the day and at night in the ACCT document. As with previous reviews the Caremap was reviewed, and no changes were felt to be necessary, as contact between him and his partner was still an ongoing issue.

78. Around the same time as the last ACCT review, the man received a letter from his solicitors about his prospects for an appeal. The letter was not available to the investigator, as all correspondence had been taken by the police. The investigator contacted the solicitor, who confirmed that the content of the letter was positive. It informed him that, having reviewed his case, the solicitors felt that there were sufficient grounds to request further funding for an appeal to be made.

79. Nothing significant is recorded about him between the last ACCT review and 23 January, and his level of risk and required observations remained the same. He continued working each day and associated with other prisoners when he had the opportunity. The entry on the front of the ACCT document indicates

that ‘4 quality entries day and night’ were required, and the entries within the document show that this instruction was followed. However, the front cover does not indicate how often he was to be observed by staff.

80. On 23 January, the man attended work in the morning as usual, and raised no concerns, returning to the wing just before lunchtime. After lunch at around 2.00pm, he went back to work, and returned to his cell at 4.45pm. The evening meal is served at around 6.00pm. However, on 23 January, this was slightly delayed due to a vehicle blocking the entrance to the wing, which meant that the trolley containing the meals could not get through. Prisoners finally began to be unlocked to collect their meals at around 6.25pm.

81. A SO was on duty on E wing helping staff to unlock the cells. He explained that he assisted an officer in unlocking the cells on the 3’s landing. He covered one side and the officer the other. When he reached cell 3-16, occupied by the man, he unlocked the door and shouted ‘tea’ as the door swung open. He said that it looked at first glance as though the man was sat on the edge of his bed, but he had his legs straight out in front of him. On looking closer, he said that he could see a ligature coming down from the bunk above and around his neck, and immediately called to the officer for assistance. He entered the cell and using his cut-down tool, cut the ligature, made of torn sheets, and lowered him to the floor.

82. The officer radioed to request further assistance, including from nursing staff as he ran to assist the SO. The two staff began cardiopulmonary resuscitation (CPR), with the SO giving chest compressions and the officer giving breaths to the man. Another officer also attended and took over from the officer giving breaths and that officer took over chest compressions from the SO.

83. A nurse was on C and D wing about to begin administering medication when the call came over the radio for him to attend E wing at around 6.25pm. He said that it was a ‘priority 1’ call, which meant that there was a medical emergency, and went directly to the wing. On arrival at the cell, the nurse saw the man lying on the floor with two officers performing CPR. He asked a student nurse who had attended with him to collect the defibrillator (AED) from the wing office and to notify the inpatient department that more nursing staff were required. He also confirmed that an ambulance had been requested. He told the investigator that he did a quick assessment of the man; there were no breath sounds, no pulse and his pupils appeared fixed. He took over giving resuscitation breaths from one of the officers, but then handed over to the student nurse who returned within a minute with the AED. He set up the AED, attaching it to the man, during which time more nursing staff arrived. The AED indicated that there was no shockable rhythm and CPR continued at a rate of 30 compressions to two breaths.

84. In addition to other nursing staff, a doctor, who was on duty conducting reception clinics also attended and took over medical management. He said that he arrived at around 6.35pm, and CPR was ongoing. He checked the man and confirmed that there was no respiratory output, his eyes were fixed and the

AED had indicated that there was no shockable heart rhythm. It was his opinion that he was dead.

85. However, as staff had begun CPR the doctor administered adrenalin to the back of the man's left hand but this had no effect. Paramedics arrived and after a handover from nursing staff attached their own defibrillator to him. This provided them with an electrocardiogram (ECG) reading, indicating a 'flat line'. The doctor explained that the protocol to be followed if a 'flat line' is shown is to check that all leads are correctly attached. The 'flat line' means that there is no electrical activity at all. He said that if parts of the heart are still alive there would be an undulating line, but in this case it was completely flat. At this point the doctor said that he did not feel there was any point in continuing with CPR and at 7.00pm pronounced the man dead.

Actions following the man's death

86. The prison arranged for all staff involved in the resuscitation attempts on the man to attend a debrief immediately after his death and they were offered support from the staff care team. Nursing staff said that they were supported by their colleagues and given the opportunity to discuss any concerns that they had. All prisoners who were subject to ACCT procedures were seen individually and an ACCT case review completed.

87. The police attended shortly afterwards. They spoke to staff involved, and removed all correspondence from the man's cell to be passed to the Coroner. This is usual in cases of self-inflicted death.

88. The investigator was told that the man had received a letter from his partner on the day of his death, and the police indicated that this might have contained information relevant to his decision to end his life. The investigator obtained a copy of the letter from the Coroner. It was a positive letter and contained nothing obvious that would have caused him any distress.

89. The Co-ordinator is one of Manchester's trained family liaison officers (FLO) and, due to her previous contact with the man's sister, was appointed as the prison's FLO after his death. As she had worked so closely with her, she had initially wanted to deliver the news to her herself, but due to his sister's home being around 140 miles away, a Family Liaison Officer (FLO) from HMP Frankland was asked to make the initial visit and break the news. The FLO from Frankland contacted the Co-ordinator later that evening. She then contacted his sister the following day.

90. The Co-ordinator explained to the man's sister that an investigation would take place and there would be an inquest into her brother's death at a later stage. An offer of financial assistance towards funeral expenses was also made. Due to his sister's concerns about press attention, the details of her brother's funeral were not shared widely so staff from the prison did not attend.

ISSUES

Medical care at Manchester

91. A clinical reviewer completed the review into the man's medical care in custody. He commented that, at both Durham and Manchester, staff reacted appropriately to his risk of self-harm. He expressed concern that, given his circumstances and presentation, there was a delay of over three weeks at Durham in getting a psychiatric assessment. However, he was satisfied that the general multidisciplinary approach to supporting him was appropriate. In particular, he noted he was regularly given the opportunity to discuss his thoughts and feelings with numerous clinical staff and he had regular contact with a CPN, prison doctors, bereavement counsellor and a visiting psychiatrist.

92. The clinical reviewer was satisfied with the management of the man at Manchester, particularly the multidisciplinary team approach towards his care and support while he lived in the healthcare unit. However, he noted that for a period of up to four weeks immediately before his death, he had no medical reviews, other than with the clinicians involved in the management of the ACCT procedures. Although he was concerned about this apparent omission and considers it unacceptable given the man's ongoing risks of self-harm, he makes no recommendations.

93. We note the clinical reviewer's concerns about lack of involvement by healthcare staff in the weeks before the man's death. When interviewed, healthcare staff and managers said their involvement was considered unnecessary as he had no physical health problems. On both occasions that he was discharged from the healthcare unit to the residential wing, he was told by nursing staff that if he required their input he should speak to staff. He raised no health concerns. A member of staff from the MHIRT attended two out of the 13 ACCT reviews held on E wing, but this was quite soon after he was discharged from the healthcare.

94. The involvement of the safer custody team at ACCT reviews was considered more relevant as they had been in contact with the man throughout his time at Manchester. We are satisfied that if he had required additional medical care, it would have been facilitated and the absence of routine medical checks in this period had no bearing on his actions.

Emergency response

95. The response by both nursing and prison staff on 23 January was timely and appropriate emergency medical equipment was quickly made available. The prison staff involved, when interviewed, demonstrated a good understanding of the actions that were required of them in such circumstances. The investigation raises no concerns about the emergency response.

Management of the suicide and self-harm prevention procedures

96. The man had been subject to suicide and self-harm prevention monitoring from his first day in custody. He was subject to constant supervision for 20 months, which is a very long period to sustain such a level of monitoring. In normal circumstances, the advice provided to prison staff is that constant supervision should be used for the shortest period possible. However, his risk factors persisted; he continued to state his intention to take his own life, and refused to engage with many case reviews. In particular, his view was that his life would continue after his death. This clearly made it difficult for the level of supervision to be reduced sooner and we are content with the decisions made during that period.

97. All decisions made about his care, including his ACCT monitoring were made by a multidisciplinary team when he was in the healthcare unit. In addition, staff spoke to his sister about his care and arranged for her to participate in case reviews. The Caremap and levels of risk were reviewed at each case review and amended accordingly, however it was not always apparent why a particular risk level had been assigned. Case reviews were clearly written, with records of discussions and concerns, but did not always indicate the reasoning behind decisions that had been taken, such as the level of risk. While case reviews were not individually numbered, all reviews were clearly dated.

98. In addition to clinical care, the clinical reviewer considered in detail the handling of staff support for the man under the ACCT procedures and how this integrated with clinical decisions. He was content with the decisions about the man's location, the assessments of his level of risk and frequency of monitoring, as well as the actions taken to address his triggers and risk factors.

99. The investigation has found that observations were carried out in line with the levels prescribed on the ACCT reviews and clear entries made on the ongoing record, which showed evidence of staff interaction. There were occasions when observations, although carried out at the required frequency, were at predictable intervals, which is poor practice. The front cover of the ACCT document should be completed to show the frequency of observations and conversations and how often these should be recorded in the document. This section had been completed, but what was written was not easy to follow and only indicated the required frequency of entries rather than observations.

100. A section on the inside front cover of the ACCT document is reserved for staff to record potential triggers that might increase the risk of self-harm. On the man's ACCT document, this section had been completed on his original document, but these had not been copied when a new front cover was added. This meant that the triggers were not immediately identifiable to staff opening the document. We make the following recommendations:

The Governor should ensure that staff conduct ACCT observations at unpredictable intervals and that this practice is enforced by regular quality checks.

The Governor should ensure that staff complete all sections of ACCT documents correctly and that the requirements are enforced by regular quality checks.

101. PSO 2700, the Prison Service policy in force at the time of the man's death, requires that staff who act as case managers in the ACCT process, must be of the rank of senior officer or above and have completed case manager training. In addition, officers temporarily promoted should also be provided with case manager training before covering such duties. The two SOs, although sufficiently senior to undertake the task, had not received adequate training. We therefore make the following recommendation:

The Governor should ensure that managers at all levels, including those on temporary promotion, have completed the necessary training before fulfilling the role of ACCT case manager.

102. The man had spent a significant amount of time as an in-patient on the healthcare wing at Manchester. We found that this was due to his required levels of observation on the ACCT, rather than for treatment of any physical health problems. However, nursing staff interacted with him daily and were fully aware of the issues which were of most concern to him, and how these could influence or change his risk levels. Therefore, it is surprising that after his discharge from the healthcare unit, none of the healthcare staff from there attended the ACCT reviews held on E wing. The investigator was told that healthcare involvement was not seen as necessary as he had no physical health issues. There was representation from the mental health in-reach team on only two occasions.

103. Multi-disciplinary reviews ensure that relevant staff and specialists are able to offer support or insight into an individual's behaviour. The fact that the man was not receiving treatment from healthcare staff while on E wing is not sufficient reason for them not to attend such reviews. While safer custody staff had good contact with him, nursing staff from the in-patients unit had most interaction with and knowledge of him during his time at Manchester. We would have expected their involvement in ACCT reviews to have continued after his discharge from the healthcare wing. Few of the reviews held while he was located on E wing were multi-disciplinary. We therefore make the following recommendation:

The Governor should ensure that, in accordance with the Prison Service guidance on the management of self-harm, all ACCT case reviews are multi-disciplinary, and involve staff who know the prisoner well to ensure continuity of approach and care.

104. At the time of the man's death, prison staff were optimistic about his progress. His risk had been assessed as low and wing staff were expected to interact with him at least four times a day and at night. Staff said that he had learned to manage his thoughts of self-harm. The only remaining matter of concern to him was the delay in arranging a transfer to another prison and the possibility of him

having to share a cell in the meantime. In spite of his actions in taking his life, we are satisfied that the level of observations were commensurate with the apparent improvement in his outlook and the achievement of the goals identified in his ACCT plan. Nevertheless, a number of shortcomings have been identified in the management of the suicide and self-harm prevention procedures.

CONCLUSION

105. The man was open at the outset about his thoughts and intentions to self-harm and remained so throughout. This led to a long period on constant supervision. This was appropriate to keep him safe and manage him over a difficult period. There were a number of significant triggers for potential self-harm identified by staff and help was offered to support him during these times. His status as a high profile prisoner also seemed to have some bearing on how he was managed.

106. One of his difficulties was the lack of contact with his partner. Prison staff arranged contact between them but, at times, this proved difficult due to her own imprisonment abroad. Regular contact between them was considered to be an important protective factor for him. It was commendable that the safer custody team involved his sister in the planning of his care which provided him with additional support.

107. He had progressed to a residential wing after spending the majority of his time in the healthcare unit at Manchester and was employed. Although, an act of self-harm in November 2011 led to a return to healthcare for a short period, he returned to the residential wing and appeared to be making good progress. Staff interviewed felt there was always the risk of him harming himself. Nevertheless, his death came as a shock to them, as it came at a time when those involved in his care thought he was making good progress and had positive plans for his future.

108. We are satisfied that with the exception of the weaknesses identified in some aspects of the ACCT process, his care was appropriate and that staff took appropriate action to minimise his risks and help to prevent him harming himself.

FAMILY RESPONSE TO REPORT

109. The man's family were provided with the draft report and opportunity to comment on the findings of the investigation. The family highlighted some factual inaccuracies and these have been amended where appropriate in the final report. Additional correspondence has been provided to clarify remaining issues.

110. In summary, the family continue to be concerned about letters removed from his cell by the police after his death. They have said that they do not know exactly what was taken, but feel that these letters could contain some information, which may give reasons for his actions. The family are also concerned that little information is available about his appeal, or whether he had received the correct documentation. The family believe that his appeal procedure would have had a significant bearing on his well-being.

111. The family are disappointed that he was allowed to be in a cell on his own, which had an obvious ligature point like the bunk bed, particularly after he had made a previous attempt to hang himself. The family feel the prison failed in its duty of care towards him by allowing this.

RECOMMENDATIONS

1. The Governor should ensure that staff conduct ACCT observations at unpredictable intervals and that this practice is enforced by regular quality checks.

   The Prison Service accepted this recommendation and said:

   A new robust quality assurance process has been developed and is now in place. These quality assurance checks are re-enforced by the Night Orderly Officer, Duty Governor and Safer Custody Team. The checks include ensuring that observations are not at predictable intervals.

2. The Governor should ensure that staff complete all sections of ACCT documents correctly and that the requirements are enforced by regular quality checks.

   The Prison Service accepted this recommendation and said:

   As above, the new quality assurance check framework will include the completion of all sections of the ACCT document.

3. The Governor should ensure that managers at all levels, including those on temporary promotion, have completed the necessary training before fulfilling the role of ACCT case manager.

   The Prison Service accepted this recommendation and said:

   All managers will be detailed to attend specific ACCT Case Manager training sessions, rather than providing dates for them to attend.

4. The Governor should ensure that, in accordance with the Prison Service guidance on the management of self-harm, all ACCT case reviews are multi-disciplinary and involve staff who know that prisoner well to ensure continuity of approach and care.

   The Prison Service accepted this recommendation and said:

   Wherever possible the prison will ensure that ACCT reviews are multi-disciplinary in line with guidelines. However, as stated in the recommendation it is important that staff who are attending know the prisoner, rather than individuals attending just because they are from a different discipline. If an individual cannot attend, but they know the prisoner well, they will be asked to provide a report.