Investigation into the circumstances surrounding the death of a man in the custody of HMP Hull in March 2008

Report by the Prisons and Probation Ombudsman for England and Wales

November 2008

Final Report

This is the report of an investigation into the death of a man found hanging in his cell at HMP Hull on 14 March 2008. Following staff efforts to resuscitate the man, he was transferred to a local hospital where he died the following day.

I pass on my condolences to the man's family and friends for their loss. I trust that this report addresses the questions that they have about his care in prison.

The investigation was carried out by one of my investigators. I am grateful to the clinical reviewer who was appointed by Hull Teaching Primary Care Trust to examine the man's clinical care. I would also like to thank the Governor of Hull. The Head of Residence and the appointed investigation liaison officer offered my investigator excellent support throughout the investigation process.

I raise concerns about alcohol detoxification, information sharing and the treatment of self harm. The man seemed to settle in well, but was subject to suicide prevention measures for one week, following an episode of self harm. The measures were lifted three days before he died.

My report contains eight recommendations for the prison to take forward, including one intended to strengthen suicide prevention measures, five for healthcare delivery, one for the bail information office and one for the Governor to consider in relation to emergency response procedures.

Jane Webb
Deputy Prisons and Probation Ombudsman **November 2008**

CONTENTS

Summary

The Investigation Process

HMP Hull

Key Events

Issues

Recommendations

SUMMARY

The man was admitted to a local mental health unit to assess his mental state following an attempted overdose on 13 February. His family described him as an alcoholic and by his own admission he was a "heavy drinker". On 18 February, he was discharged from the unit, drank whisky and committed his alleged offences. Police took the man into custody where he remained for two days, until he was remanded to HMP Hull on 20 February, following a court appearance. This was his second time in custody. His first experience of prison was a short sentence in open conditions in 2000.

During his first reception healthscreen at Hull, the man laughed with staff about how he had ended up in prison. He told them he took the overdose on 13 February so that he would be sectioned and receive treatment for his alcoholism. He said he had no intention of harming himself. The man's manner was cheerful according to the nurse leading the healthscreen, although the observing nurse felt that he was masking his anxiety. She noticed no signs that he was withdrawing from alcohol. The lead nurse assessed that the man was not at risk of suicide or self harm but made a mental health referral.

The next morning the man saw the doctor for his secondary health check. The doctor assessed him as having no mental or physical health needs. He did not think that the man was at risk of self harm or suicide. The mental health assessment took place later that day. Again, the primary care mental health team leader did not identify any mental health problems and the man assured her that his alcohol misuse issues had been dealt with at the mental health unit earlier in the month. In fact, the man had yet to undergo a clinical detoxification. The team leader decided that he needed no further mental health supervision.

The man went through his induction and settled well on the wing. His solicitor wrote to the Bail Information Office to try to secure a hostel placement so that he could spend his time awaiting trial in the community, rather than in prison. The Bail Information Office did not receive the correspondence in time for a court hearing on 27 February, so the hearing was adjourned until 4 March.

The adjourned videolink hearing went ahead on 4 March (a court appearance where the defendant appears by video conferencing facilities rather than in person). The man was refused bail on the grounds that he had failed to address his alcohol misuse needs. Another hearing was scheduled for 18 March. The man was upset by the videolink hearing. He took an overdose of what he thought were 32 paracetamol tablets (in fact it is likely that they were two sanitising tablets and a number of sweets). He alerted staff that he had taken an overdose and was taken to be examined by a nurse. The nurses on duty were not convinced that the man had taken an overdose. They checked his pulse, blood pressure, temperature and pupil dilation. They did not refer him to hospital or take a blood test and no mental health referral was made. He was checked by a nurse later that night, who could find not physical symptoms of an overdose.

Officers started suicide prevention measures. During the night the man shaved his eyebrows off, but no mention is made about this in his records. The suicide

prevention measures continued for a week, during which time no further concerns were raised. Following a review, the suicide prevention measures were stopped.

The man was visited by his solicitor on 12 March. The solicitor had no concerns about his wellbeing following their meeting. Two days later, a prisoner who had become friends with the man on the wing went to see him in his cell. He was hanging from the metal bracket supporting his toilet. The prisoner could not support the man's weight on his own and called for assistance. Another prisoner came to the cell and helped to support the man's weight.

Officers on the wing heard shouting and made their way to the cell. They took over from the prisoners, thanked them and asked them to leave. Officers cut the ligature around the man's neck and the cord that was bound around his wrists. They started resuscitation efforts until healthcare staff arrived within minutes. Nurses continued to resuscitate until the paramedics arrived. The paramedics administered adrenaline and the man showed signs of life. He was transferred to the local hospital, where he remained unconscious until he died the following morning.

THE INVESTIGATION PROCESS

1. I appointed an investigator from my office to conduct the investigation into the circumstances surrounding the man's death. The Head of Residence immediately organised for the man's prison records to be copied and sent to my investigator. Notices were sent to the prison to invite prisoners and staff to contact my office with any information they thought was relevant to the investigation. There was no response to these notices.

2. The investigator was unable to open the investigation within the customary three days and visited the prison on 2 April to meet staff and collect additional information. She met the Deputy Governor and her investigation liaison officer. During this visit, she also met the Detective Constable leading the police investigation. (All deaths in custody are subject to an initial police investigation before I can continue with my investigation.) The Detective Constable confirmed that the police were not treating the death as suspicious and were happy for my investigation to go ahead. I am grateful to the police for sharing relevant information with my investigator.

3. A Clinical Governance Manager was appointed by Hull Teaching Primary Care Trust (PCT) to conduct a review into the clinical care that the man received while he was at Hull. I would like to thank the clinical reviewer for her co-operation with the investigation process and for the comprehensive review which has been so valuable to this report.

4. After a thorough review of the paperwork, the investigator arranged to visit Hull to interview staff and prisoners. She contacted the man's cellmate who had been transferred to Durham prison, and conducted a telephone interview with him.

5. One of my family liaison officers contacted the man's brother, the listed next of kin. He discussed his concerns about the man's care at Hull and suggested that my family liaison officer contact the man's daughters. My family liaison officer, accompanied by my investigator, visited the man's daughters and wife who expressed concern about the treatment that he received for his substance misuse. They were also anxious to discover why the man was not subject to suicide prevention measures when he died. I have examined these issues in the report.

6. Following her meeting with the family, the investigator was joined by the clinical reviewer to conduct joint interviews with officers and healthcare staff. She interviewed another of the man's cellmates who was still at Hull. My investigator wrote to the man's solicitor for information about the outstanding criminal matters. I am sincerely grateful for the information that he provided for the investigation in his written response. The clinical reviewer joined my investigator for follow-up interviews at the end of May. My investigator then conducted telephone interviews with the members of the Bail Information Office.

HMP HULL

7. Hull is a local prison that serves the Yorkshire and Humberside Area. As with all local prisons, it is under constant pressure to accommodate the large numbers of prisoners that make up its ever-changing population.

8. Her Majesty's Chief Inspector of Prisons carried out her last full inspection in November 2005. Hull has changed considerably since the time of that inspection due to the closure of a much-criticised unit. At that time, the Chief Inspector found that "the healthcare centre provided a good service".

9. In her examination of the substance misuse resources at Hull, the Chief Inspector focussed on the increasing support available to prisoners who used drugs rather than alcohol. She concluded that the policy was still under development and training needs of staff were beginning to be addressed. The Integrated Drug Treatment Service (IDTS) unit opened in September 2007. Predominantly for the treatment of prisoners withdrawing from drugs, those going through alcohol detoxification are also supervised on the unit. It is a discrete wing with extra healthcare staff, where only prisoners going through detoxification are located and receive additional support.

10. The Measuring the Quality of Prisoner Life (MQPL) survey, carried out in November 2007, found a small majority of prisoners negative about relationships between prisoners and staff. This was in contrast to the Independent Monitoring Board's finding, in its annual report for 2006/7, who found staff "dedicated and loyal". A number of prisoners who participated in the MQPL survey expressed frustration at the lack of employment opportunities. The Inspectorate found "the overall quantity of purposeful activity remained insufficient, with prisoners spending too long locked up in their cells".

11. The man's death was the first apparently self-inflicted death at Hull in 2008. At the time of writing, no other prisoner has died by apparently self-inflicted means, although there have been four deaths by natural causes so far this year.

KEY EVENTS

12. The man was remanded to Hull on 20 February, following a court appearance at North Lincolnshire Magistrates court. A self-harm warning form was completed by court staff. It recorded the man's attempted overdose on 13 February and that he had made statements of intent to self-harm. Court staff passed the form to escort staff, who, in turn, passed the form to an officer working in reception. The reception officer signed the warning form to acknowledge its receipt. It was filed in the man's wing history and a copy taken for his clinical record.

13. While the man was in reception, two other officers completed a cell sharing risk assessment. The purpose of the assessment is to determine whether it is safe for a prisoner to share a cell. They referred to the Prisoner Escort Record (PER) and warrant. As discussed, there was an asterisked message on the warrant, "*PLEASE NOTE – DEFENDANT IS VULNERABLE*". However, the officers did not mention the man's highlighted vulnerability on the cell sharing risk assessment. Once the relevant section was completed, the form was passed to the nurse in the first night centre for her counter-signature as the healthcare professional on duty that evening.

14. The Head of Healthcare has set up a system whereby any documents that indicate a prisoner's vulnerability must be faxed through to her in the healthcare centre by reception officers. The man's warrant was duly faxed through to her. Although she could not specifically remember the warrant, she told my investigator that she would have checked the man's records to see if any action had been taken by staff. The Head of Healthcare said that she would have been satisfied to see a referral had been made for a mental health assessment and so taken no further action.

15. The man's first reception healthscreen took place at 8.40pm. (A first reception healthscreen is an assessment of the immediate mental and physical health needs of a prisoner.) The healthscreen was held in a private room on the first night centre so that there was confidentiality. The first night nurse completed the healthscreen. A newly appointed nurse observed the interview as a training exercise. The first night nurse said that the healthscreen normally takes about 15 minutes and involves the prisoner answering a number of set questions about their mental and physical health.

16. She recorded that the man had been treated at a local mental health unit for an "alcohol detox". The man told the first night nurse that he took the overdose on 13 February following his wife's instructions in order to be admitted to a psychiatric unit for treatment for his alcohol misuse. (He retracted this version of events in his final letter.) He told the nurse that he "had no intentions at all" of self harm. The man explained that he drank whisky after being discharged from a local mental health unit and then he committed his offence. The first night nurse did not refer him for further work with his substance misuse. When asked why she had not referred him in interview for this investigation, she said:

"Because I didn't feel like he was withdrawing. They usually have to have some, showing some signs of withdrawal before … if he had seen the doctor would have identified that, if had some of the signs, the doctor would have referred him on."

17. Following the man's healthscreen, the first night nurse referred him for a mental health assessment. She could not specifically remember why she made the referral, but on checking his records during interview, said it was likely to be due to the recent discharge from the mental health unit and an outstanding appointment. The first night nurse also made a referral to the doctor to check the man's hypertension.

18. The self harm warning form from the court staff accompanied the man into his first reception healthscreen, as did the records from his short time in police custody. During the screening, the first night nurse signed the self harm warning form and confirmed that she had not opened an ACCT document. (ACCT stands for Assessment, Care in Custody and Teamwork and is the system used to identify and support prisoners at risk of suicide or self-harm.) She was satisfied that the man was not at risk of self harm at that time. She described the man as relaxed and joking about how he had ended up in prison. He said that he had been forced to take the overdose on 13 February and he had no intention of further self-harm. He made good eye contact and his body language was relaxed. The newly appointed nurse's impression was that the man's laughter was masking anxiety. However, she was satisfied that this would be addressed by the mental health team.

19. After the completion of the healthscreen, the first night nurse turned to the cell sharing risk assessment. In response to the question, "Following the self-harm assessment have any concerns been raised?", the nurse indicated that they had not. She went on to write, "no evidence of risk to self/others". The man was assessed as being a low risk and was located in a residential shared cell in the first night centre. During interview, the first night nurse said she would not normally look at a warrant, so she did not see the asterisked message about his vulnerability. The man told her that he was not at risk of self harm and so she recorded that there were no concerns.

20. Unbeknown to staff, the man had been in the local mental health unit for a period of assessment. Although he was given medication to stabilise him through the assessment, it was not a formal detoxification. When asked during interview whether she thought the man's drinking on the day of his discharge reflected the success, or otherwise, of his apparent detoxification, the first night nurse said, "it obviously didn't work did it". When asked how she would have found out what happened to the man at the local mental health unit, she said that she would not have been able to find anything out that night. The nurse explained that often healthcare staff have to go on "face value" about what is wrong with a prisoner. However, she did have access to police records that documented his inebriated state at the time of his offence and subsequent arrest. On this occasion, she said that the man showed no signs of alcohol withdrawal, which she described to my investigator as "shaking, sweating, pins and needles, things like that".

21. The following morning, the man had a health check with a doctor employed through an agency to provide a doctors' service to the prison. He started working in mid-February and so had been working at Hull for about a week when he carried out the man's assessment. All prisoners see a doctor when they arrive at prison for a health assessment. During this routine appointment, the man told the doctor that he had successfully completed a detoxification programme at the local mental health unit. The doctor noticed no signs of alcohol withdrawal and did not discuss the man's alcohol misuse with him any further. The man explained that he had been taking antidepressants and antihypertensives for high blood pressure, but that he had taken nothing over the last ten days. The man said that he felt much better and preferred not to take medication. The doctor found "no physical or mental health issues". The doctor told my investigator that he did not request the man's medical records from the local mental health unit because the man did not present with any worrying symptoms that required treatment. In the doctor's opinion, the man was not at risk of self-harm. Although the doctor was not familiar with the ACCT process, but he said he would have asked for the man to be admitted to the inpatient healthcare centre for constant supervision or referred him for a mental health assessment if he was concerned that he was at risk to himself. The doctor noticed that the man was due to see the mental health team for an assessment later that day.

22. The Team Leader for the Primary Mental Health team carried out a mental health assessment the same day, following the first night nurse's referral. She also found no evidence of mental health problems. During the assessment, the man, "reported a history of problems following what he described as being given large amounts of medication and alcohol by his wife. After treatment in hospital he now feels a new man".

23. The primary care mental health team leader explained to my investigator that the primary care mental health team use a specific assessment form to assess a prisoner's mental health. She said that a prisoner can be offered between six and ten weekly sessions with the primary care mental health team and are constantly reviewed during that time. The mental health assessment examines a prisoner's level of risk, mood, cognitive ability and whether the prisoner is suffering from severe and enduring mental illness. She described the first assessment as "a screening process built up through a process of discussion" with the prisoner. The team leader said that in order to assess risk, she looks at a prisoner's body language. She explained indicators of risk might be as follows: "no eye contact, they appear to be in a withdrawn state, they appear to be unhappy, they appear to be distressed in some way or no communication as well".

24. The primary care mental health team leader said that if a prisoner is showing symptoms of withdrawal, her team would refer them to the substance misuse team on the IDTS unit. Only after a formal detoxification could her team be usefully involved in a prisoner's care. She remembered carrying out the man's mental health assessment. She said:

"… at the time I saw him he was quite happy and cheerful really. I remember him talking about how he had, he had an alcohol problem and had just recently been in hospital … and had quite positive thoughts for the future at that point in time and I didn't determine any risk at all and no risk of suicide".

25. When the man spoke to her about his use of alcohol, she said, "he talked about that as if it wasn't current and as if it was a long time before". Following her assessment, the team leader was satisfied that the man was not in need of further support from the primary care mental health team.

26. The man's solicitor wrote to my investigator with details of the contact his firm had had with the Bail Information Office, throughout the man's time at Hull. The original bail application requested release to the man's parents' address and was refused because it would have been too close to the alleged victim's home. The prosecution's solicitors indicated that they would not oppose a bail application to an address outside his home area. On 21 February, after the man's remand to custody, the firm sent a letter to the Bail Information Office asking that a hostel place be found.

27. There are two Bail Information Officers working at Hull. One of the officers said that she did not receive the letter from the man's solicitors until it was faxed through on 27 February, after checking his records. Nevertheless, meeting a Bail Information Officer is part of each prisoner's induction process. The Bail Information Officer could not specifically remember her initial meeting with the man on 21 February, but there is a record of it having taken place. The purpose of the meeting was to establish if he had any bail needs, and as the man did not have a bail address, the Bail Information Officer identified that he needed either supported housing or a hostel placement. She said that there was "nothing alarming" about the meeting. It is not the role of the Bail Information Officer to discuss a prisoner's substance misuse needs, apart from establishing if there are any. The man denied any problems with alcohol.

28. While he was on the first night centre the man completed the five day induction programme to familiarise him with the rules and regimes of the prison. As part of the induction assessment, he had an interview with a CARATs worker. (The Counselling, Assessment, Referral, Advice and Through Care Services is a nationwide treatment programme for prisoners who have misused drugs or alcohol.) Officer Norrie confirmed that the man was told about CARATs and how the workers could support him for his alcohol misuse. The man had no recorded contact with CARATs during his time at Hull. Due to the nature of his charges, the man was not given access to the pin phone system or a first night telephone call. According to Prison Service Order (PSO) 4400, the Governor must take steps to ensure that communication from prisoners charged with an offence under the Protection from Harassment Act 1997 is effectively monitored.

29. Once the man had completed the induction programme on 26 February, he moved into the main area of the prison, to a shared cell on C wing. He shared this cell with another prisoner who said that they got along well. My investigator

spoke to the other prisoner during the course of the investigation. He described the man as “an alright guy”, who smoked a lot. The prisoner said that he respected the man as an older prisoner and looked after him. Although the man did not leave his cell very much, the prisoner said he had no problems with other prisoners and got along well with staff.

30. The man was scheduled to appear at court via videolink on 26 February. When his solicitors contacted the Bail Information Office to discover whether they had found a hostel placement, they were informed that the office had not received the original request for a bail address sent on 21 February. The solicitors faxed the letter again. The videolink hearing was adjourned, due to the lack of a proposed bail address. Despite this exchange, at around 3.00pm the next afternoon, the Bail Information Office faxed the man’s solicitor’s to ask advice as to whether a bail application was to be made on the man’s behalf. The solicitors again faxed the Bail Information Office on 27 February, requesting that a hostel placement be found. The solicitor made it clear that the prosecution were prepared to agree bail, as long as the hostel placement was away from the area where the alleged victim lived. They attached a case summary of the man’s alleged offence and previous convictions.

31. During interview, the Bail Information Officer explained that as soon as possible after the initial bail information meeting, she contacts a prisoner’s solicitor to find out whether they intend to make a bail application, and determine what the prisoner’s bail needs are. The Bail Information Officer wrote a letter and faxed it to the Man’s solicitors on 26 February asking whether he needed a bail application. She said that this would have been her earliest opportunity to contact the solicitor due to her workload at that time. The Bail Information Officer said that she had not received the letter from the solicitor dated 21 February that crossed in the post as she sent the fax. Once the solicitor received her fax, they faxed through a copy of the letter already sent by post on 21 February.

32. A list is kept in the Bail Information Office with all of the contact numbers for bail hostels in the area. The Bail Information Officer said that she called all of them and there were no spaces available. Even if there had been any spaces available, she thought it would have been unlikely that a bail hostel would have given the man a place. She said that bail hostels usually only accept high risk prisoners and his criminal history meant that he was considered a low risk prisoner. However, in any event there were no hostel spaces on 27 February, which is why she then decided that the man should be referred to ClearSprings. (ClearSprings is a private company commissioned by the Home Office to provide supported accommodation for people leaving prison.) ClearSprings take low risk prisoners who appear in certain courts in a specified area. The man came into the ClearSprings catchment area, and they were prepared to look at an application from him. The Bail Information Officer did not have time to complete the man’s application for ClearSprings herself and left a request for her colleague, the other Bail Information Officer, to complete it on her behalf when he returned from leave on 3 March.

33. Upon his return from leave, the second Bail Information Officer was clearing his backlog and asked his colleague, a probation worker in the Public Protection Office, to interview the man for the ClearSprings application. The probation worker had previously completed bail hostel applications, although it was not part of her core function at the prison. The probation worker remembered going to the wing to speak to the man in an interview room at about 2.30pm on 3 March. She told my investigator that the man "appeared fine" and was co-operative with the application process. She went through the form and asked all the required information. The man wanted to talk to her about the circumstances of his alleged offence but she said that she brought him back to the task in hand. The probation worker said that she would never tell a prisoner whether they were likely to get a hostel placement or not, because it is not the Bail Information Officer's decision and she would not want to raise their expectations. According to the probation worker, she returned back to the Bail Information office and passed the completed application form to the second Bail Information Officer. The second Bail Information Officer said that it was the probation worker who faxed the application form to ClearSprings, but her recollection was that the second Bail Information Officer must have done it. The application form, completed by the probation worker, was faxed to ClearSprings without the necessary case summary. ClearSprings rejected the application on the grounds that the man was in denial of his alcohol needs. When the man's solicitor contacted ClearSprings, they were told that the application was rejected because the required case summary was missing from the application.

34. Meanwhile, the man had settled on the wing. Officers described him as a quiet prisoner, who did not leave his cell much, even during periods of association. He appeared at a Magistrates Court via videolink on 4 March. He told his cellmate that he was expecting to be released to a bail hostel. The solicitor thought this was a reasonable assumption at this time. The case was further adjourned until 18 March. Again, the prosecution assured the man's solicitor that they would have no objection to bail, as long as hostel placement could be organised.

35. The man's solicitor spoke to him in a private booth after the videolink hearing. In his letter to my investigator, he wrote:

> "[The man] was more upset and annoyed by the presence of his wife's sister than his further remand. [I] recall explaining to him that whilst there had been problems with the bail hostel referral, it seemed that a final decision was very close in that regard and that should the prosecution be as good as their word once they had an address away from the area then bail ought to be a formality. [I] also explained to [the man] that his wife's sister was perfectly at liberty to be in court during the hearing and that her presence made no difference in the way in which that case was going to be dealt with."

36. Although the solicitor recognised that the man was upset, he was not unduly concerned about his wellbeing during the interview. He told my investigator

that he did not think it necessary to speak to a member of prison staff about what had happened that day.

37. The man was remanded back into custody until 18 March. The prisoner who he shared his cell with at that time told my investigator that the man changed after this court appearance. He said that he was made angry by his wife's sister during the hearing. He told the other prisoner that if it was not for his support, he would kill himself. The prisoner said that although staff at Hull were approachable, he did not tell them about the man's threats of suicide. He said that he did not think that the man was making a serious threat to harm himself.

38. At about 7.30pm, the man was in his cell when he called over an officer. He said that he had taken 32 paracetamol tablets and two other tablets that he did not recognise. (These tablets were sanitising tablets from a dispenser on the wing.) The man was not prescribed paracetamol tablets. The officer took the man to the first night centre where the first night nurse and the newly appointed nurse who had seen the man on reception were on duty. The newly appointed nurse was the first to examine the man and was concerned about him. She checked the man's blood pressure, temperature, pupil dilation and pulse, all of which were normal. She said that she was worried that the man had taken an overdose but also did not see any physical symptoms.

39. The newly appointed nurse sought advice from the first night nurse, who examined the man and said that she did not think that he had taken an overdose. She would expect the man to have a stomach ache, slurred speech and be sweating. She said that he just seemed angry about the videolink appearance. The first night nurse did not make a mental health referral or take a blood sample. The newly appointed nurse said she would have liked to take the man to outside hospital but thought that the matter was "taken out of my hands … as though I'd lost control and someone was totally overruling anything that I said". The newly appointed nurse did not express her concerns at the time. When she handed over to the night shift, the first night nurse instructed the nurse on the night shift to check if any symptoms had developed. When she checked the man, the night nurse also found no evidence that he had taken 32 paracetamol tablets. The clinical reviewer explains that there is a "lack of early symptoms" following a paracetamol overdose and recommends that a patient is "transferred to hospital urgently".

40. The officer told my investigator that the man thought that these tablets were paracetamol tablets. However, when the officer returned to the man's cell to search for evidence of what he had taken, there was no physical evidence that he had taken any paracetamol tablets. Instead, the officer found wrappers for mints sweets, which he thought the man may have mistaken for paracetamol tablets. Nevertheless, following the man's reported overdose, the officer raised a Concern and Keep Safe form, in accordance with ACCT procedures. He did not sign or date the form. The man told this officer that, "he was going to do something bad, and he could not cope any more. He also stated he was going to hang himself." It was agreed that an officer should have a conversation with the man every morning and afternoon and irregular observations were to be

made throughout the night shifts. The man was given a letter explaining the ACCT process.

41. The prisoner sharing a cell with the man remembered him shaving off his eyebrows that night. When he asked him why he had done it, the man could not explain. The prisoner said he understood that his bizarre behaviour was because he was upset about the videolink. No mention is made of the man's eyebrows in his ACCT record.

42. The following morning, an ACCT assessor completed an ACCT assessment interview. Officers receive special training to become ACCT assessors. This was the ACCT assessor's third ACCT assessment and she told my investigator that she was confident with the process. The man told the ACCT assessor that all of his problems "related to his wife". He blamed her for his imprisonment and repeated his accusation that she had, "been overdosing him with depression pills and alcohol", (that he later retracted). When the man was asked to describe the last 48 hours and what might have led to him self-harming, he talked about the videolink appearance. He said "it all got too much for him" but that he did not want to die. It was just a bad day and he had other family to think of. He told the ACCT assessor that "he could not see it happening again". The man said that he got on well with his cellmate and had no problems about approaching staff for help.

43. The ACCT assessor attended an ACCT case review later that day. A senior officer (SO) chaired the review. The man said he felt fine after having a long conversation with the prisoner he shared a cell with. He told the officers that he had no intention of self-harming. The man was identified as being a low risk of self harm or suicide but the ACCT document remained open, to be reviewed on 12 March.

44. Later that afternoon, the prisoner sharing with the man moved cells. During his conversation with my investigator, he explained that he was concerned about sharing a cell with someone who was talking about suicide and did not think he could cope with that pressure. Another prisoner was moved into the man's cell. The cellmate heard from other prisoners that the other prisoner had been moved because he was suspected of bullying the man. There are no security records to support this, and no entry was made in the man's wing file or the wing's observation book to this effect. The other prisoner's security record shows no intelligence was received about bullying throughout his time in prison. An officer recorded that the man was associating well with other prisoners and getting on well with his new cellmate.

45. One officer on the wing recorded that he had a "good chat" with the man on 7 March. The man said that he was "fine and dandy" and had made the decision to move forward with his life, once the court case and sentence were out of the way. He told the officer he was, "going to move to a new area and start again". Four days later, an officer had another conversation with the man, who asked when he was going to be taken off the ACCT document. The officer recorded that he had "no concerns at present".

46. According to the man's family, he met his solicitor on 11 March. His family understood that he told his solicitor "if you don't get me out of here, I'll do something stupid". The solicitor confirmed that there was no meeting that day, but his colleague visited the man on the afternoon of 12 March.

47. An ACCT case review was chaired by the same SO as chaired the previous review on 12 March at 11.15am, a few hours before the man's legal visit. The man attended the review and was "in good spirits". The man remained unemployed at that time, but during this review agreed to make use of the employment opportunities in the prison. The ACCT document was closed. The post closure interview was scheduled for 20 March.

48. A colleague of the man's solicitor visited him for one and a half hours that afternoon:

> "[My colleague] from our office saw [the man] at Hull Prison on 12 March in the afternoon. He spent an hour and a half with him and took a full statement from him. … [My colleague's] assessment of [the man] was that he seemed perfectly normal if not cheerful and gave him no cause for concern as to his welfare. He made no comments during that interview about intending to harm himself."

49. Another prisoner on C wing described himself as the man's friend. He told police that when he saw the man on 13 March, he was "cheerful, happy and relieved that he had someone to talk to regarding the problems with his wife/partner".

50. Every morning at 7.45am, prisoners are unlocked for a period of exercise. There are seven officers and one senior officer working on the wing during the morning shift. Every prisoner is unlocked but it is their decision as to whether they choose to exercise or not. They return to their cells at 8.15am. Prisoners who attend work and education are allowed out of their cells to make their way to their respective activities. At about 10.00am, all other cells are unlocked and prisoners associate on the wing or carry out domestic tasks like changing laundry or cleaning their cells for the morning until about 11.20am.

51. At around 10.40am on 14 March, an officer was conducting accommodation fabric checks in each cell on the fourth landing of the wing where the man was located. (Daily accommodation fabric checks are performed by officers to check that the cells are secure.) The officer regularly works on C wing and knew the man. He remembered going into the man's cell. The man was sitting on the bed drinking tea or coffee. The officer asked him if he was alright and he said, "yeah, I'm okay". The officer said "there was nothing apparent to trigger any concerns". The cellmate told my investigator that other prisoners had noticed the man leaving his cell six or seven times that morning, looking around and then returning to his cell.

52. The man's friend had just finished showering at 10.57am and made his way to the man's cell to visit him. When he walked into the cell, he saw the man's foot sticking out from behind the toilet screen. The man's friend called his name but

got no response. He noticed the man had been sick. He bent down to check the man and saw him hanging with a shoelace around his neck, attached to a low level toilet bracket. The prisoner tried to lift the man and release the pressure from the lace. The man's hands were also tied behind his back with a piece of nylon cord. (The cord was the same material used to bind bundles of newspapers for distribution on the wing.) The prisoner could not manage to lift the man and so he pressed the cell bell to raise the alarm. He shouted at other prisoners to help him, but those nearby seemed to be in a state of shock. He approached a larger prisoner who he thought would be able to support the man's weight. The other prisoner followed the man's friend into the cell. The other prisoner supported the man's weight with his right arm, while trying to release the pressure of the ligature with his left hand.

53. An officer was working on the third landing of the wing when he heard prisoners shouting. He immediately made his way to where the noise was coming from, one landing up. The officer arrived within seconds. He entered the cell and saw the man on his knees with a ligature around his neck, being supported by two prisoners. Two officers and an SO followed the first officer into the cell. A principal officer (PO) was behind them and stayed in the cell doorway. The first officer assisted to support the man's weight. Another officer reached over to the ligature and cut it with his anti-ligature knife. One of the prisoners pointed out that the man's hands were tied together. The female officer used her ligature knife to cut the nylon cord around his hands. The officer who cut the ligature and the SO lowered the man to the floor, ready to start cardio-pulmonary resuscitation (CPR). One of the prisoners recalled that he tried without success to find a pulse. The two prisoners were thanked for their efforts and asked to leave the room.

54. The female officer and the SO could not find a pulse. The man was not breathing and the female officer noticed that his lips were blue. The SO started chest compressions and the female officer started mouth to mouth resuscitation. The first officer to the cell made a Code Blue radio call, which means medical emergency – breathing difficulties. The PO requested an ambulance over the radio. This was within minutes of the earlier radio call.

55. The Senior Staff Nurse was on A wing when she heard the Code Blue radio call. A wing is close to C wing and the senior nurse immediately made her way to C wing with the first night nurse who was nearby. In the meantime, the PO instructed the first officer to collect the emergency grab bag from the staff office. Another officer was asked to collect the defibrillation kit from A wing, about one minute away from C wing.

56. The nurse detailed to respond to emergencies that day was attending a non-urgent medical situation on B wing when she heard the radio call. The senior nurse and the first night nurse reached the man's cell first, about three minutes after he was found hanging. The senior nurse took over chest compressions. Shortly afterwards, the emergency response nurse arrived at the cell. The first night nurse had retrieved the oxygen from the emergency bag and passed it to the emergency response nurse. The emergency response nurse took over from the female officer and inserted the ambubag into the man's mouth to give

him oxygen. The nurses applied the defibrillator during their resuscitation attempts but it advised not to shock. The nurses continued for around 20 minutes, until paramedics arrived at about 11.20am. The paramedics inserted a tube into the man's throat and injected adrenaline into his arm. They found that his heart had started again for a short while and compressions were started again. More adrenaline was injected. The man's condition was stabilised and he was transported to the local hospital.

57. The ambulance left Hull at 12.05pm and arrived at the hospital five minutes later. The man was taken straight to Accident and Emergency to continue his treatment. At 12.25pm, hospital staff discovered a note in the man's pocket. The envelope was addressed to his wife. On the reverse of the envelope the man had written that he wanted to go to the university. Subsequently, my investigator has learned that this referred to his long-standing wish to donate his body to science. The man was not explicit in his letter about his intention to die. He said his "sickness, headaches and toilet problems" were coming back and that he was fed up all the time. He also wrote that he suffered from cold sweats most days. He apologised to his wife for telling lies about her and asked for her forgiveness. The police collected the note an hour after it had been discovered, as part of their evidence gathering exercise. The man had a computerised tomography (CT) scan and then returned to the Accident and Emergency Department.

58. Although the Head of Security was not the Duty Governor on 14 March, he offered to help liaise with the man's family. The governor said that the prison wanted to make sure that the family were notified as quickly as possibly because of the man's critical condition. Ordinarily, the prison would elect their own representatives to visit the family, but it was decided to ask the local police to inform the family. Unfortunately, the wrong house number was given to the police and this resulted in a delay in breaking the news to them.

59. The governor was notified when the man's brother had arrived at the hospital. He went to speak to him personally because he thought it was appropriate that a governor was present to receive the family and answer any questions. He took the man's brother to a quiet room in the hospital and explained what had happened. The man's parents then arrived and he took them to one side and gave them the same explanation. The man's family went to his bedside. The governor arranged for the escorting prison officer to stand outside the hospital room. The man had no restraints on him. Two uniformed police officers were stationed outside of the hospital room.

60. A bed watch log was started by the two escorting officers, just as they were informed that the man was to be transferred to the Intensive Care Unit at about 2.30pm. The bedwatch log was started as the escort record finished. Another officer took over the bedwatch at 7.15pm. The man's family continued to arrive throughout the night and stayed with him. At 6.05am, the family were informed that the man had passed away, although his death had not been pronounced by a doctor. Shortly afterwards, they left the hospital. A hospital doctor pronounced the man's death at 6.45am.

61. The bedwatch officer contacted an officer in the command suite at the prison at 8.00am to notify her of the man's death.

Prisoner Support

62. Once staff had arrived at the man's cell, the prisoners were thanked and asked to leave the cell. I am pleased to see the prisoners' efforts were appreciated and they were appropriately asked to leave the cell, while staff continued with resuscitation efforts.

63. The prisoners who attended the cell commended staff's efforts to resuscitate the man. The man's friend told police, "the officers and myself did everything we could to save him and [officers] acted very professionally in trying to revive him".

64. The police interviewed the man's friend and the prisoner who assisted him shortly after the man was transferred to hospital. The police also analysed the bindings around the man's wrists to ensure that there had been no third party involvement in his death. They were satisfied that the binding was tied by the man himself. The police concluded that there were no suspicious circumstances surrounding his death.

65. When the man was transferred to hospital, two of the officers who attended the emergency went to speak to the two prisoners who assisted to tell them what had happened. The man's cellmate was intercepted on his way back from education. He remembered alarms going off while he was in his morning class but did not know what had happened. When he got back to the wing, an SO took the cellmate into a private office to explain that the man had been taken to hospital and his prognosis was not good.

66. After the man's death, the Governor issued a notice to prisoners, which was posted around the prison. The cellmate organised a collection for some flowers to be sent to his funeral. With the help of an SO, the cellmate also circulated a condolence book for prisoners to express their sympathy, which was sent to the man's daughters.

67. A memorial service was held in the prison chapel in the days following the man's death. The family heard that the service had been cancelled, however, it went ahead, despite low attendance.

Staff Support

68. All staff, including healthcare staff, involved in the resuscitation efforts were invited to a hot debrief after the man had left the prison on 14 March. (A hot debrief is a meeting to give staff the opportunity to share their feelings following involvement in a traumatic incident.) Officers told my investigator that they found it helpful to go through what had happened. The female officer raised her concern that she performed mouth to mouth without a face mask and was issued with one during the meeting.

69. Other staff learned of the man's death when they next came on shift. There were notices posted around the prison. Prison Service staff said they felt well supported by the welfare team, who also attended the hot debrief. However, healthcare staff said that they were not allowed to access support from the Prison Service welfare service and were not clear who to go to. They sought support from their colleagues and found that this was effective. Although I make no formal recommendation, the Head of Healthcare will wish to ensure that staff are aware of the support services available from Hull Teaching PCT.

Family Liaison

70. As explained above, the man's family were informed of his death by the local police and there was some delay in doing so, due to confusion with the house number. Prison Service Order (PSO) 2710 suggests that it is good practice for a representative of the prison to break the news. (PSO 2710 governs the prison's response to a death in custody.) In this case, I think the prison were right to ask the local police to break the news on their behalf because the priority was for the family to get to the hospital as soon as possible. The delay is regrettable. The prison offered to pay reasonable funeral expenses in accordance with PSO 2710.

71. When my investigator and my family liaison officer met the man's daughters and his wif, they had several concerns that they wanted the investigation to address. They were worried about the nylon cord that the man used to bind his hands together. They were surprised that such material was readily available to prisoners on the wing. My investigator discovered that the cord was likely to have been the material used for the distribution of newspapers on the wings. There are no security restrictions on this material.

72. The man's family were also worried that he was only subject to suicide prevention measures for one week during his time at Hull. They said that he was good at masking his anxiety, but expected staff to look beyond his immediate presentation and identify that he was at risk of suicide. My investigator asked the first night nurse, the doctor and the primary care mental health team leader to describe the non-verbal signs that they look for when assessing a prisoner's risk of self-harm. The man did not speak with his cellmate with whom he had formed a good relationship, about suicide or thoughts of self harm. With hindsight, it is likely that the man was at risk of self harm at the time staff made their assessments. However, staff looked for appropriate body language and presentation and I do not think that their assessments were unreasonably made. I explore this matter at greater length later in the report.

73. The man's family were also concerned that he told his solicitor explicitly that he was going to kill himself after the court hearing on 4 March. My investigator spoke to the officer on duty in the videolink office that day. She said that she is trained in ACCT procedures and would open an ACCT document if she thought a prisoner was at risk of self harm or suicide. She could not recall any prisoner who was particularly distressed on 4 March. The family asked my investigator to find out whether the solicitor spoke to any member of staff about the man's

suicide threat. In his letter to my investigator, the man's solicitor said that he did not think that the man was at risk of suicide after that hearing, although he was upset by a relative's presence. Therefore, the solicitor did not have any concerns to pass on to staff.

74. The man's family are worried that his mental health and substance misuse needs were not formally identified and properly addressed at Hull. In some respects, I share their concern and will go on to examine the treatment that he received in more detail below.

ISSUES

Should the man have been in prison?

75. The man first applied to be bailed to his parents' address. The application was refused on the grounds that the address was too close to the alleged victim. At this early stage, the prosecution indicated that they were unlikely to have any objection to the man being bailed to an address outside his local area.

76. When the man's solicitor wrote to my investigator, he was concerned that the Bail Information Office had not effectively dealt with the man's bail hostel application. He wrote:

    "What we can say however is that this is a case where [the man] would have been granted agreed bail had the hostel referral process run more smoothly than it did. If he had been bailed to a hostel whether [the man] would have gone on to harm himself is a matter for conjecture."

77. Prison Service Order (PSO) 6101 sets out mandatory requirements for Bail Information Schemes in prisons. The aim of the schemes is, as follows:

    "Prison-based schemes target defendants who have failed to secure bail at their first court appearance and could benefit from assistance in applying for bail at their second or subsequent appearance."

78. The first letter of 21 February requesting that the Bail Information Officer locate a hostel placement went missing. I am prepared to accept that these things happen, however regrettable the consequence. However, I am concerned about the apparent inefficiency of the referral on 4 March. PSO 6101 says:

    "Bail Information Officers … must identify risk factors and areas of need and ensure that relevant information is included in the referral to [the service provider] and in the bail information report to the court."

79. A link to the bail referral form is annexed to the Order. The form has a list of required information. Emboldened in the centre of that list is 'Case Summary'. There is a warning at the bottom of the form that it must be faxed by 3.00pm with the accompanying information for a referral to be considered for that day. The case summary was not attached to the bail application.

80. The man's bail application was ultimately refused due to his outstanding alcohol needs. These needs were not identified or treated at Hull. I am satisfied that the Bail Information Office's inefficiency did not fatally affect the man's bail application. However, I am concerned about the resources and the apparent miscommunication around the man's bail application.

    The Governor must assess and, where necessary, improve the efficiency of the bail information office.

Clinical Care

Clinical Review

81. Hull Teaching PCT commissioned a Clinical Governance Manager to review the clinical care that the man received while he was in custody. The clinical reviewer had access to the man's medical records and conducted joint interviews with my investigator. The clinical reviewer also called for the records of the man's time at the local mental health unit, the week before he was taken into custody.

82. The clinical reviewer concluded that the first reception healthscreen, the doctor's assessment and the mental health team leader's assessment were "timely, appropriate and comparable to services within the community". The clinical reviewer does not discuss the assessment of the man's substance misuse needs in her review. However, she was concerned that the man's medical records do not appear to have been requested from his community practice.

83. She was concerned about the treatment that the man received after his alleged overdose on 4 March and in particular that there was no mental health referral. She makes one recommendation about patient records and four about the response to his alleged paracetamol overdose. I agree with the clinical reviewer's recommendations and commend them to the prison and the Primary Care Trust for further attention. I have considered the clinical reviewer's findings in the next sections of my report.

Why did the man not receive any treatment at Hull for his alcohol misuse?

84. The man arrived at Hull three days after he had been discharged from the local mental health unit. He told staff that he had undergone a detoxification programme and felt like a "new man". The first night nurse was aware that the man had drunk whisky on his release and was drunk when he was taken into police custody. The man's inebriation was well-recorded by police and the first night nurse acknowledged that she saw the police medical documents. During her interview with my investigator, the nurse conceded that the detoxification programme "obviously didn't work", if he got drunk immediately on his discharge. Still, she made no referral to the doctor for detoxification. Despite the evidence available to her, she took the man at his word because he presented as relaxed and gave her no cause for concern.

85. The doctor said that he could see from his entry in the medical record that the man had told him he had undergone a successful detoxification from alcohol. The doctor saw no signs of alcohol withdrawal, such as sweating or shaking. He said that he referred to the first reception healthscreen to inform the assessment. When asked his opinion about the man's drinking upon discharge from his apparent detoxification at the local mental health unit, the doctor said that he could not remember seeing that in the screen and that it was concerning. He did not recall seeing the first night nurse's handwritten entry in the medical record, which sets out the events of 18 February more clearly. The

doctor said that he has contacted a prisoner's doctor during a secondary healthscreen to verify the medical history if he had reason to doubt that the prisoner was giving him an accurate account of his needs. He did not contact the man's community doctor or the local mental health unit because he had no reason to doubt that the man had not been through a successful detoxification. When asked what resources there were for prisoners going through an alcohol detoxification, the doctor said that if he thought that the man required an alcohol detoxification programme, he would have referred him to the substance misuse team on the IDTS unit. (IDTS is a discrete unit where prisoners who are detoxifying from drugs and alcohol are accommodated for the duration of the detoxification programme.)

86. In the final letter that he wrote to his wife, the man described the symptoms he was experiencing, "Something's not right again? Started to sweat most days and nights. (Cold Sweats)." He said that he had "headaches, sickness and toilet problems". All of these symptoms are classic symptoms of alcohol withdrawal. Withdrawing from alcohol is not only physically painful but it can affect a person's mental state.

87. I am concerned that vital medical history was not known to the prison to inform the man's care. I understand that each healthcare professional was qualified to make their own judgement about the man's mental health and substance misuse needs based on how he presented to them at the time of their assessments. However, this case is a reminder of the importance of verifying a prisoner's medical history. I appreciate that even if the records were requested from the man's GP or directly from the local mental health unit, they would not have arrived in time to inform these assessments. I am surprised that no one contacted the local mental health unit to verify the treatment that he received so shortly before he reached the prison. I am equally surprised the man's medical records were not called for, despite a system for their retrieval being in place. I agree with the clinical reviewer's recommendation:

    The Head of Healthcare must strengthen the system whereby a prisoner's' medical history is requested from the relevant community service provider, if any substance misuse, physical or mental health needs are identified during the initial healthscreens.

88. During interview, the Head of Healthcare explained that the man could have been admitted to the IDTS unit at Hull. There the man would have received a clinical detoxification. His treatment would have been observed by the staff on the IDTS, who include nurses and healthcare assistants. The Head of Healthcare acknowledged that the man would not have received support from CARATS had he been admitted to the IDTS unit, as CARATS at Hull do not support prisoners going through an alcohol detoxification, only those detoxifying from illegal substances. In fact, she said that there were no psycho-social resources available for prisoners going through alcohol detoxification. She believed that no national funding had been allocated for such resources.

89. The Deputy Governor told my investigator that the prison were aware of a lack of resources for prisoners undergoing alcohol withdrawal. With that in mind,

the prison has already met with local healthcare services to develop a pilot for the Alcohol for Good Lives (AFGL) programme. The Deputy Governor said that the pilot was in its early stages when the man was in the prison. As he had not been identified as in need of alcohol detoxification, it is doubtful whether he would have received such a programme. None of the healthcare staff interviewed during the investigation seemed to be aware of the pilot. They all expressed concern at the lack of psycho-social resources available to help prisoners going through alcohol withdrawal.

The PCT should provide support mechanisms for prisoners going through alcohol withdrawal.

I am pleased to note that the PCT have advertised for a substance misuse specialist nurse since the man's death.

Were the man's mental health needs met in prison?

90. The first night nurse referred the man for a mental health assessment because she knew he was going to miss an appointment at the mental health unit due to his remand to custody. She thought that he might have had ongoing mental health needs. She did not ask for the man's medical records from the mental health unit because she had made a mental health referral and thought the doctor would see the man the next morning. She told my investigator that the doctor or the primary care mental health team would request the man's community records if they were needed to inform his ongoing care.

91. The doctor's assessment took place on the man's first morning in Hull. During interview, the doctor said:

> "what I have entered in my records is that he didn't have any physical or mental health issues. That means that I would have seen him face to face and I would have assessed that he wasn't depressed, he must have been having good eye contact and talking normally and he mentioned about having a successful detox, alcohol detox recently at that time and he said that he's trying to stay away from alcohol till that point when I saw him."

92. The doctor went on to say that he could see from the man's medical notes that he was due for a mental health assessment later that day. He told my investigator that he did not normally have access to a prisoner's records at the time of a secondary healthscreen. He said that he would have a copy of the first reception healthscreen, but that is a brief summary of the prisoner's immediate medical needs. The doctor assessed the man on the basis of his presentation at interview and what he said during the secondary health screen. He had no concern for the man's mental health.

93. All mental health referrals go to the newly established Primary Care mental health team who carry out a review within 24 hours of prisoners who have just arrived at Hull. The team leader was scheduled to work in the reception and induction area of the prison on 21 February. She remembered the man's mental health assessment and described him as being "happy and cheerful"

throughout their interview. She completed a Primary Health Questionnaire (PHQ) 9. Despite the first night nurse's note on the referral form, the team leader said she was not aware of how recent the man's alcohol problems were and got the impression from him that his stay at the mental health unit was a long time before his arrival at the prison. She said that she did not request the man's medical records from the mental health unit because she did not consider that he needed further mental health supervision.

94. No mental health referral was made following the man's apparent overdose on 4 March. The officer who raised the concern and keep safe form did not make a referral. The first night nurse did not consider it a serious act of self-harm and did not think it necessary to make a mental health referral. The newly appointed nurse felt that the situation was out of her control, but she also mistakenly thought that the man was being seen by the mental health team following his referral at the first reception healthscreen. The ACCT assessor did not make a mental health referral following her assessment of the man as part of the ACCT process. This is in spite of the PHQ9 form being attached to every new ACCT document, for officers to consider whether there were any outstanding mental health issues. The ACCT assessor said that she was sure that the man did not have any mental health issues. She said that if she was concerned, she would have telephoned the healthcare centre and asked for someone to make a mental health assessment.

95. It is a matter of concern that the man was not referred for a mental health assessment following his attempted overdose. In fact, it was likely that he swallowed a number of mints, believing them to be paracetamol tablets. That the act of self harm caused no physical damage does not diminish the intention that the man had to harm himself. When the mental health team leader learned of the man's attempted overdose, she was concerned that he had not been referred for a mental health assessment. The Head of Healthcare was surprised and concerned that no referral was made at that time. I agree with the clinical reviewer that staff awareness of mental health processes should be improved:

The Head of Healthcare and Governor must support the Head of the Primary Care mental health team in promoting awareness among all staff of the mental health referral system.

Was the medical response to the man's alleged overdose attempt appropriate?

96. I have already discussed the fact that no mental health referral was made following the man's alleged attempted overdose on 4 March. It appears that he did not actually take paracetamol tablets because only wrappers for confectionary were found in his cell. However, it is likely that he believed it was a genuine attempt to overdose. The newly appointed nurse was the first healthcare professional to examine him and she took his blood pressure, pulse and measured his pupil dilation and temperature. However, as a relatively new member of staff, she sought advice from a more experienced nurse in the prison setting, the first night centre nurse. At that point, the newly appointed

nurse described the situation as being taken out of her control, although she did not raise this at the time. The first night centre nurse assessed the man's manner, discovered that he did not have a stomach ache and concluded that it was unlikely that he had taken the overdose.

97. The first night centre nurse is an experienced nurse in the prison health setting. I am concerned that the man's substance misuse needs were not identified at first reception, and am not satisfied his alcohol problem was sufficiently explored. I am particularly concerned that the first night nurse did not effectively treat his apparent overdose on 4 March and did not make a subsequent mental health referral. The man approached staff following this overdose attempt. This was the only time he showed any vulnerability in prison. This may have been a crucial missed opportunity.

98. The clinical reviewer expressed her concern about the assessment of the man's condition. She commented particularly on the fact that his blood was not tested and the lack of policies and protocols at Hull for dealing with an alleged paracetamol overdose. I commend the following recommendations made in her review to the PCT:

Development of multi disciplinary procedural guidelines are required to emphasise to staff current best practice in the care of patients presenting with an alleged self induced poisoning.

99. I am pleased to learn that such policies are already in development. At the time of writing the draft report, they are being considered by the PCT ready for full implementation later this year.

All patients who allege to have taken an overdose who do not require immediate transfer to the hospital should be monitored until the self induced poisoning can be confirmed or discounted.

100. The family had the opportunity to comment on a draft of this report before it was finalised. They were concerned that the man's next of kin were not contacted by the prison after he had allegedly taken an overdose. They also asked why staff did not chase up the man's medical records. My investigator asked the clinical reviewer to look at this matter as far as healthcare staff were concerned. The clinical reviewer responded as follows:

> "The PCT in Hull held no records for [the man]. No records were requested following the alleged overdose attempt as at that time the staff did not perceive an overdose had occurred and did not refer him for further treatment. Previous medical records would not have his changed his care as they may still not have been in receipt, it can often take several weeks for a GP to send on health records. Immediate care is determined by assessment of the patient at the time regardless of previous notes."

I am concerned that the family were not contacted following an apparent episode of self harm. Officers opened an ACCT document in order to monitor

the man's level of risk to himself. I hope that the Governor will work with the Head of Safer Custody to remind staff of the importance of involving a prisoner's family at times of crisis. Even where the prisoner does not want staff to contact their family, efforts should be made to encourage the prisoner to make contact himself.

Did staff respond appropriately when the man was found in his cell?

101. As soon as the prisoner shouted for assistance, officers made their way to the man's cell. They appropriately took over the situation from the two prisoners and asked them to leave.

102. The female officer did not have a face mask, but continued with mouth to mouth resuscitation. I am concerned that staff do not routinely have pocket face guards for their own protection. There is no requirement for staff to carry pocket face guards, although it is recognised by the Prison Service as "good practice".

The Governor should consider issuing all staff with pocket face guards to carry with them at all times.

103. The paramedics continued resuscitation attempts and transferred the man to hospital. The clinical reviewer expressed no other concerns about the emergency response to the man's discovery.

Should the man have been subject to suicide prevention measures?

104. The man arrived in custody on 20 February with a suicide and self harm warning form, a Prisoner Escort Record and a court warrant. All three documents flagged his vulnerability. The escort record and the self-harm warning form both explicitly referred to his overdose on 13 February. However, an ACCT was not opened by officers on reception or the nurse, following her first reception healthscreen.

105. During interview, the first night centre nurse described the man as "quite jolly really, didn't seem apprehensive". She said that she had a long conversation with him and the newly appointed nurse, observing the healthscreen, about how he had "ended up in prison". The first night nurse said he made good eye contact, seemed relaxed and caused her no concern. The nurse told my investigator that she does not look at court warrants as part of the healthscreen, but did look at his escort record and the suicide and self-harm warning form. She asked the man about his overdose. He told her that he was forced by someone else to take a number of pills in order to get admission to the local mental health unit. He had wanted to go through an alcohol detoxification. The two nurses believed the man's account of the overdose. The first night nurse did not think he intended to take his own life. She asked him if he had any ongoing thoughts of self-harm, which he denied. Taking into consideration his relaxed demeanour, the first night nurse was satisfied that he was not at risk of self harm or suicide.

106. The newly appointed nurse was concerned at the man's level of anxiety but was satisfied that he would be seen by the mental health team, because the first night nurse had made a referral. The newly appointed nurse told my investigator that she had not received ACCT training. She started work at Hull in January 2008 and her induction had consisted of observing staff until she felt ready to perform healthcare tasks by herself. At the time of her interview in May, she still felt unprepared to do first reception healthscreens. I am surprised that newly appointed nurses do not routinely receive ACCT training.

107. The doctor assessed the man the next morning. When my investigator interviewed him, he could not specifically recall the assessment, but referred to the entry he made in the man's medical record. He said that he was not concerned that the man was at risk of self harm or suicide. He had not received training in ACCT procedures, but would have either admitted the man to the healthcare inpatients' unit for constant supervision or made a mental health referral, if he was concerned about his level of risk. I am concerned that a medical professional involved in the assessment of prisoners at such a vulnerable time of their custody was not familiar with the suicide prevention measures in place at the prison.

The Head of Healthcare and Governor should ensure that all permanent healthcare staff undergo ACCT training this financial year and that agency staff are briefed on suicide prevention systems before they carry out healthcare assessments.

108. The Primary Care Mental Health Team Leader carried out a mental health assessment later that morning. For the assessment, she had access to the mental health referral from the first night nurse and the entries detailed on the electronic medical information system (EMIS). She found the man to be "quite happy and cheerful really". She said that he felt "a lot better and quite relieved" to have undergone a successful detoxification. When my investigator asked the team leader how she can tell whether someone is at risk of suicide or self-harm, she said:

> "We're looking really around body language at that time. You know it's often the case that somebody who may be saying they don't feel suicidal, that often those what you're picking up is on the body language and maybe there's no eye contact, they appear to be in a withdrawn state, they appear to be unhappy, they appear to be distressed in some way or no communication as well."

The mental health team leader did not think the man was at risk of self harm.

109. Three healthcare experts with experience of working with prisoners did not consider the man at risk of suicide or self harm. When my investigator met the man's family at the beginning of her investigation, they asked her to look into why his risk was not identified. With the benefit of hindsight, it is clear that the man was capable of hiding his anxiety and it is possible he hid his true feelings from the first night nurse, the doctor and the mental health team leader. The man was consistent in his story about the circumstances surrounding the

overdose attempt on 13 February. His final letter to his wife is the first indication that this story was not true. The man admitted that he had lied to staff and his solicitor in the letter that was found on him by hospital staff. The information made available to my investigator about the man's time at the local mental health unit paints a clearer picture of a man in crisis. The erratic behaviour that led to his remand was not known to staff assessing him in his first few days at Hull. Such behaviour is an indicator of risk. On balance, while it is regrettable, I cannot say it was unreasonable for staff not to have opened an ACCT document given the facts available to them at the time of their assessments. It must also be borne in mind that two weeks passed following the healthscreen without any indication that the man was at risk of self harm.

110. The man did not express any concern or anxiety in the intervening days to warrant a reassessment of his level of risk. On 4 March, he approached an officer on the wing, claiming that he had taken a significant number of paracetamol tablets and some sterilising tablets. The first night nurse checked the man for the physical symptoms of a paracetamol overdose. The clinical reviewer subsequently advised that no such symptoms would normally be evident for some time after an overdose. She did not think that the man had taken the overdose because he was not experiencing any stomach pain or dizziness. The first night nurse recalled that the man was apologetic and rather embarrassed to have taken the pills. She did not think he was at risk of self-harm or suicide at the time. Despite being unsure whether the man had taken paracetamol tablets, the officer who took him to see the nurse subsequently raised a Concern and Keep Safe form, the first stage of the ACCT process. The newly appointed nurse, still not trained in ACCT procedures at this point, remembered feeling anxious about the treatment the man had received following his alleged overdose. She felt that the situation had been taken out of her hands. However, she did not express this to anyone at the time.

111. An ACCT assessment was carried out the next day. The ACCT assessor thought that the man had reacted to a bad videolink appearance and the risk he posed to himself had probably decreased as he calmed down. She attended the first ACCT case review, together with an SO and the man. The SO chaired the review as he was the manager for the wing that morning. He did not know the man from the wing but used the ACCT assessment and the man's presentation during the case review to inform his judgement. He agreed with the ACCT assessor that the man was probably no longer at risk to himself, but kept the ACCT document open as a precaution. The man was told about support available to him through the Listeners and his personal officer. (A Listener is a prisoner who has been trained by the Samaritans to support prisoners through periods of crisis.) He was to be checked every shift and at irregular intervals throughout the night. An ACCT ongoing record was kept and showed staff's regular interactions with the man. No concerns were reported during the week after his self harm attempt.

112. As scheduled, a follow-up ACCT case review took place on 12 March, chaired by the SO again. The only other member of staff present was another officer from C wing. The decision was made to close the ACCT. The SO remembered the man being "upbeat" during the meeting. The man talked

about taking employment at the prison. Although he is not trained in mental health, the SO drew on his many years of custodial experience to assess the man and felt that he was no longer at risk.

113. During the seven days the ACCT was open, the man's personal officer, (the female officer who attended the emergency), was not at work. (A personal officer is a point of contact for a prisoner for any queries or concerns.) Nor did he access the Listeners. However, the SO thought that he was no longer at risk of self harm. Given his presentation at the case review and the facts available to the SO at the time, the decision was again, regrettable but reasonable. I am concerned that no healthcare staff were invited to attend the meeting. According to ACCT guidance, case reviews should be multi-disciplinary. The attendance of a healthcare staff member might have alerted the mental health team to the man's self harm attempt.

114. The family were concerned that the man had been visited by his solicitor the day before his ACCT document was closed. They thought he might have reacted badly to the visit. They were worried that the information about the solicitor's visit was not properly considered by the staff who closed the man's ACCT document. During interview, the SO confirmed that he did not know that the man had a recent legal visit. They did not discuss any matters relating to his legal representation.

115. In fact, the man's solicitor confirmed to my investigator that a colleague from his office saw the man on the afternoon of 12 March. The ACCT case review took place at 11.15am, before the legal visit took place. In his account of the legal visit, the man's solicitor wrote:

> "[A colleague] from our office saw [the man] at Hull Prison on 12 March in the afternoon. He spent an hour and a half with him and took a full statement from him. … [my colleague's] assessment of [the man] was that he seemed perfectly normal if not cheerful and gave him no cause for concern as to his welfare. He made no comments during that interview about intending to harm himself."

116. Even if the SO had been aware of the man's forthcoming legal visit, he gave no cause for concern during that interview. If the legal visit had affected the man's state of mind, he gave no indication of it to his cellmate or staff on the wing.

117. In conclusion, it is unfortunate that the man could not communicate his feelings to staff. The final letter that he wrote to his wife demonstrated his feelings but recognised that he had lied about his circumstances, particularly surrounding his attempted overdose on 13 February. The man appears to have been expert in hiding his anxiety and staff were unable to discern his true state of mind.

Conclusion

118. The man's family told my investigator that he was good at hiding his feelings. He masked his anxiety throughout his time at Hull. However, opportunities were missed for simple information sharing which might have improved the

care that he received. Healthcare staff in the first two days did not refer to each other's entries thoroughly enough and did not gain a full understanding of his substance misuse needs. The way that the man presented himself to staff as cheerful meant that this might have made no difference to the outcome in this case, but may make a difference in future cases.

119. However, I am satisfied that staff appropriately assessed the man's body language and looked for signs of alcohol withdrawal at the time of his reception. The man showed no signs of risk to himself until 4 March when an ACCT document was opened, to be closed a week later after due consideration of his presentation at the review meeting. A mental health referral should have been made following this attempted self harm. Sadly, the man died three days after the ACCT document was closed.

RECOMMENDATIONS

1. The Governor must assess and, where necessary, improve the efficiency of the bail information office.

   The Prison Service partially accepted this recommendation. Their response was:

   > *"We have two full time bail information officers who see every unconvicted prisoner who comes into Hull prison. To enhance this, group meetings are now being carried out on A wing. Reports are sent to the courts and referrals are made for accommodation when not available."*

2. The Head of Healthcare must strengthen the system whereby a prisoner's' medical history is requested from the relevant community service provider, if any substance misuse, physical or mental health needs are identified during the initial healthscreens.

   The Prison Service accepted the recommendation and have put into a place a random audit to ensure compliance.

3. The PCT should provide support mechanisms for prisoners going through alcohol withdrawal.

   The PCT accepted this recommendation and recruitment processes for a specialist alcohol misuse/substance misuse nurse are underway.

4. The Head of Healthcare and Governor must support the Head of the Primary Care mental health team in promoting awareness among all staff of the mental health referral system.

   The recommendation was accepted. In response, the prison wrote:

   > *"Increased staff training and awareness of service. Service specification to be included on induction of new staff and Primary Care Mental Health to discuss service at team meetings and governance forums."*

5. Development of multi disciplinary procedural guidelines are required to emphasise to staff current best practice in the care of patients presenting with an alleged self induced poisoning.

   The recommendation was accepted and at the time of response, a draft of the guidelines were out for consultation.

6. All patients who allege to have taken an overdose who do not require immediate transfer to the hospital should be monitored until the self induced poisoning can be confirmed or discounted.

   The recommendation was accepted and has been incorporated into the policy document.

7. The Governor should consider issuing all staff with pocket face guards to carry with them at all times.

   The prison accepted this recommendation and have placed an order for face masks.

8. The Head of Healthcare and Governor should ensure that all permanent healthcare staff undergo ACCT training this financial year and that agency staff are briefed on suicide prevention systems before they carry out healthcare assessments.

   The prison partially accepted this recommendation, writing:

   > *“Due to staff turnover and service requirements, may not be feasible for ALL staff to complete within this financial year. Scoping to be completed to ascertain which staff require training and all new staff to receive training on induction, all other staff who have not received training will be followed up once scoping complete”.*