Investigation into the circumstances surrounding the death of a man at HMP Manchester in April 2009

Report by the Prisons and Probation Ombudsman for England and Wales

December 2010

This is the report of the investigation into the apparently self inflicted death of a man. The man was found hanging from the window bars in his cell at HMP Manchester less than 48 hours after he arrived at the prison.

I offer my sincere condolences to the man's family and friends. Initially, my office's investigation was suspended while Greater Manchester Police conducted enquiries on behalf of the Coroner, which inevitably led to delays to the investigation. However, I apologise for the further delays in issuing the report and any additional distress this has caused to the man's family and friends.

The investigator and I would like to thank the Governor of Manchester and his staff for their co-operation with this investigation, particularly as it came some six months after the man's death. I am very grateful to the Safer Prisons team, who provided invaluable help to the investigator.

Manchester Primary Care Trust (PCT) commissioned a doctor to review the clinical care provided to the man while in prison. I am very grateful for his considered review.

The man had never been in prison before. He had been found guilty of harassment (not an offence associated with increased risk of self harm) and was remanded into custody to await sentencing. Shortly before his arrest, he made a number of cuts to his body. The man had a history of depression and high blood pressure. Prison staff quickly placed him under suicide and self harm monitoring procedures.

The man's first hours in custody were unusual. He was taken to hospital shortly after he arrived at the prison due to chest pains, returning in the early hours of the morning. However, staff who had contact with him on his return and later that day, found him to be quite relaxed and had no particular concerns that he might try to harm himself again. The suicide monitoring procedures were ended during the man's first day in prison.

Although I have reservations about the decision to end the monitoring and have identified some omissions in the care he received, I am pleased to note that the Governor has already acted on a number of these. The clinical reviewer makes no recommendations, judging that the clinical care provided to the man was equitable to what he could have expected in the community. I make one recommendation, to ensure that all prisoners receive a full induction on their arrival. However I do not think that this would have prevented the man's death. I conclude that, although there were reasons to be concerned about him, his actions were not foreseeable.

I am very grateful to the man's family, who took the time to consider and comment on the draft version of this report.

Jane Webb
Acting Prisons and Probation Ombudsman **December 2010**

CONTENTS

Summary	4
The investigation process	6
HMP Manchester	7
Key events	9
Issues	19
Conclusion	25
Recommendations	26

SUMMARY

The man appeared in court on 21 April 2009, was found guilty and remanded into custody to await sentencing. He had never been in prison before. Escort staff looking after him during the day opened a Suicide/Self Harm Warning Form because he had made a number of cuts to his body the day before, shortly before he was arrested by the police.

On his arrival at the prison in the early evening, the man told staff about the cuts and said he had been suffering with depression over the last few months. He said he was prescribed antidepressants, but had not been taking them because they were not working. The man also said he had a history of high blood pressure and had recently undergone a procedure to check his coronary arteries were not blocked. Reception staff decided that the man should be monitored under the prison's suicide and self harm prevention procedures.

While in reception, the man saw the prison doctor who noted that the self-inflicted cuts were superficial. The man told him he had no thoughts of suicide or harming himself again. He said, however, that he had felt pains in his chest during the day. As a result, he was taken to hospital to undergo tests. The man told the officers who escorted him to hospital that he had a number of personal problems and was worried about being in prison. (The staff did not record details of their conversation in the relevant files.)

The man returned to the prison in the early hours of the morning of 22 April. Following the tests carried out in hospital, he was admitted to the prison inpatients unit for observation. A member of staff carried out the first night interview and had no concerns about him.

The following day, a healthcare senior officer interviewed the man to assess the risk he posed to himself. He said he had no thoughts of harming himself and his only concern was that he had trouble sleeping. The officer made arrangements for the man to see the prison psychiatrist the following morning. The man said he wanted to visit the prison library and the officer thought this was an indication that he was making plans for the future.

The same officer then chaired a case review with the man, two mental health nurses and a member of the chaplaincy team. Again, he reassured them he had no thoughts of harming himself. All those present agreed that the monitoring procedures could be stopped.

Staff checked the man during the night and had no concerns about him, noting that he appeared to be sleeping well. However, during a routine check shortly before 6.00am on 23 April, a member of staff found the man hanging from the window bars in his cell. Staff quickly went into his cell and cut the ligature. They began cardio pulmonary resuscitation (CPR), which continued until the paramedics arrived. Unfortunately, the man could not be resuscitated and he was pronounced dead at 6.10am.

I make one recommendation as a result of this investigation, concerning making sure that all prisoners receive a full induction during their first days in prison. I have considered the decisions staff made in relation to the risk the man posed to himself and conclude that they could not reasonably have foreseen that he would go on to take his life.

THE INVESTIGATION PROCESS

1. My office was informed of the death of the man on 23 April 2009 and the investigation was allocated to an investigator later that day. The investigator visited HMP Manchester to open the investigation on 29 April. She met the member of the Independent Monitoring Board who was on duty the day that the man died. She was shown around the prison and spoke informally to some staff who had contact with the man during his short time there.

2. The investigator issued notices inviting staff and prisoners to contact her with any information they felt might be relevant to the investigation. There was no response to these notices.

3. The prison provided the investigator with relevant documentation covering the man's time in prison, including copies of his prison and medical records and staff incident statements written after his death.

4. At the request of Greater Manchester Police (GMP), the Ombudsman's investigation was suspended shortly after the man's death while the police conducted enquiries on behalf of HM Coroner. I am very grateful to GMP for sharing information with the investigator. The Ombudsman's investigation recommenced in October 2009. HM Coroner was contacted and informed of the nature and scope of the investigation and provided the investigator with a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist with his enquiries.

5. Manchester PCT commissioned a doctor to undertake a review of the clinical care the man received while in prison. The clinical reviewer and the investigator carried out a number of joint interviews with staff in December 2009. The investigator received the clinical reviewer's review in April 2010. The investigator completed her interviews with staff in February 2010. As the investigation had been suspended for approximately six months following the man's death, some staff struggled to remember the details of their contact with him. A great deal of the evidence considered as part of the investigation came, by necessity, from the written information recorded by staff during the man's time at Manchester.

6. One of my family liaison officers contacted members of the man's family to explain the purpose of my investigation and invite them to raise any questions or concerns to be considered. The man's family felt he should have been subject to constant monitoring and questioned why this was not the case. I hope this report provides them with a better understanding of the man's time at Manchester. The man's family was provided with copies of the draft report. Following this, his sister asked that the content of her telephone conversation with him on his arrival at Manchester was re-considered. She thought that the reference to the conversation in the draft report "understated" her brother's frame of mind. The conversation has been re-examined and further information provided.

HMP MANCHESTER

7. HMP Manchester is a category A local prison serving the courts of the Greater Manchester area. It holds up to 1,269 adult male prisoners on remand, convicted and sentenced. The prison became part of the high security estate in April 2003. However, as a local prison, it accommodates both category A and other category prisoners.

8. The National Offender Management Service (NOMS) publishes quarterly performance ratings of prisons in England and Wales, with each prison being assessed across a number of set indicators. Over the last three published quarters, Manchester's performance has been deemed "good", the second highest possible rating.

9. HM Chief Inspector of Prisons (HMCIP) last carried out a full announced inspection of the prison in July 2009. The inspection report noted that Manchester "has always tried to ensure that it can meet the needs of the great majority of its prisoners", whilst ensuring it also fulfils its role as part of the high security estate.

10. HMCIP found "good" self harm and suicide procedures in place and noted that Assessment, Care in Custody and Teamwork (ACCT) documents were generally "reasonably well completed". However, case reviews were frequently not multi-disciplinary. The Inspectorate highlighted some good relationships between staff and prisoners although their research indicated that a number of prisoners lacked trust in staff. Healthcare services at the prison, including the inpatient unit, were found to be good although inpatients spent too long locked in their cells each day.

11. Each prison in England and Wales is also monitored by an Independent Monitoring Board (IMB) formed of volunteers from the local community. IMB members have full access to every prisoner and all parts of the prison. The Board produces an annual report, with the most recent available for Manchester covering the period 1 March 2007 to 29 February 2008. The IMB reported that Manchester was a "well-run prison" and staff showed "sensitivity" in their dealings with prisoners. The Board reported that at least half of all prisoners managed under the ACCT process were located in healthcare, resulting in added workload on healthcare staff. The prison had noted this and additional staff had been allocated to the unit at night.

Assessment, Care in Custody and Teamwork (ACCT)

12. ACCT is the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be started by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (when staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at

all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night. As part of the process, regular multi-disciplinary review meetings must take place. Wherever possible, the prisoner at risk is also included in review meetings.

Previous deaths at Manchester

13. There have been 15 previous self-inflicted deaths at Manchester since the Ombudsman began investigating all deaths in prisons in 2004. I have found no particular similarities between the circumstances of those deaths and that of the man. However, in 2004, the Ombudsman made a recommendation to Manchester concerning the recording of information in the relevant files, something I comment on in this report. This was accepted by the Prison Service at the consultation stage and I am disappointed that it has not been fully achieved. Since the man's death, there have been a further three apparently self-inflicted deaths at Manchester.

KEY EVENTS

14. On 21 April 2009, the man appeared at a local magistrates' court and was found guilty of harassment. He was remanded into custody until 5 May, when he would be sentenced, and arrived at HMP Manchester at 6.20pm. It was his first time in prison. Escort staff delivered the man to reception and gave the senior officer (SO) in charge that evening, copies of the man's Person Escort Record (PER) and Suicide/Self Harm Warning Form. (The PER Part A highlights any risks the escorted prisoner may pose to themselves and others. Part B serves as an ongoing record of the prisoner's time whilst being escorted and should be updated by escort staff during the day. The Suicide/Self Harm Warning Form must be completed by escort staff if they have any concerns that the escorted person might try to harm themselves. It must be passed to reception staff at the prison.)

15. The PER recorded that the man had been collected from a local police station at 7.30am that morning. Prior to his arrest, he had cut his wrists and ankles. Because of his actions, a member of G4S staff (the private company responsible for escorting prisoners in the Manchester area) opened a Suicide/Self Harm Warning Form at 8.05am, recording that the man had harmed himself "due to domestic problems". The man told G4S staff he was "still a bit upset but does not intend to self harm today". Both the SO and a nurse who was working in reception that evening, signed to say they had seen the Suicide/Self Harm Warning Form.

16. At 7.00pm, while he was still in reception, the man was placed on an ACCT plan by a officer. The officer was interviewed as part of the investigation. She explained that when a prisoner arrives with a Suicide/Self Harm Warning Form, reception staff spend time asking the prisoner about how he feels and will explore any information recorded on the form. Staff then decide whether an ACCT plan needs to be opened.

17. The man told the officer that he had recently separated from his partner and that, over the last eight or nine months, he had begun to suffer with depression. He said he was being prescribed antidepressant medication by his community doctor. He admitted having made deliberate cuts to his arms and legs before he was arrested. He showed the cuts to the officer. She did not think they looked serious but was concerned that he might try to harm himself again. As a result, and because she also knew it was his first time in prison, she decided that the ACCT procedures should be opened.

18. The officer completed the Concern and Keep Safe form, the first stage of the ACCT process, recording that the man had harmed himself before he was arrested. She wrote that he was "in a very low mood at the moment", was suffering with depression and not sleeping well. The officer, the SO and the man then completed the Immediate Action Plan (the second stage of the ACCT process). They decided that the man should remain in the reception holding room until he could be moved to his allocated cell and reception staff should keep an eye on him. Staff told him that he could speak to a Listener (a prisoner trained and supported by the Samaritans to offer a confidential listening service to other prisoners) and he was allowed to make a three minute telephone call to his sister.

The prison provided my investigator with a recording of that call. (All telephone calls made by prisoners are recorded and kept for a period of time. In some circumstances the conversation will be listened to by prison staff. Staff did not listen to the man's call at the time.) The man told his sister he felt "a bit shitty". During the call, he appears to express his frustration about the events of the day. He and his sister agreed that he could not "go any lower". The investigator heard nothing in the conversation to indicate that the man might be thinking of harming himself.

19. The investigator interviewed the SO about his contact with the man. However, due to the passage of time, the SO could not remember very much about the meeting or being involved in the opening of the ACCT. He said however that he did not have any particular concerns about him at the time and did not see the cuts the man had made to his arms and legs.

20. The officer and the nurse completed the Cell Sharing Risk Assessment (CSRA). (This assesses the level of risk the prisoner poses to other prisoners and whether they are suitable for sharing a cell.) The officer recorded that the man was on an open ACCT and "states he is very anxious". The man described himself as someone who got frustrated easily. Both the officer and the nurse concluded that he posed a low risk to other prisoners and was suitable to share a cell.

21. At 7.24pm, the man was assessed by another nurse who completed the First Reception Healthscreen. (The purpose of the healthscreen is to identify any immediate mental or physical health problems requiring referral to the doctor or other specialist service.) The man told the nurse that he was prescribed amlodipine and valsartan (to treat high blood pressure) and citalopram (an antidepressant). However, in interview, the nurse said the man told her that he had not been taking his antidepressants recently because they were not working. He said that he had trouble sleeping and his community doctor had planned to change the medication to mirtazepine (another type of antidepressant) to help this. The man asked to be prescribed mirtazepine in prison. The nurse told him that, before this could happen, healthcare staff would need to confirm his prescribed medication with his community doctor. She also said that he would need to be assessed by the mental health inreach team (MHIT, which works with prisoners on the wings who have mental health problems), who would decide the appropriate treatment.

22. The nurse recorded that the man had recently harmed himself, and had cut his arms and upper right foot. In interview, she described the cuts as "superficial". She thought he might have made the cuts in frustration, because of "what was going on in his life". The nurse recalled that he said it was the first time he had cut himself. She looked at the wound dressings, which had been applied at hospital following his arrest, and made an appointment for them to be reapplied on 26 April. She also referred him to the MHIT for assessment.

23. The man told the nurse that he had seen his doctor in the last three months following chest pain, and had an angiogram three months previously, which had not identified any problems. (During an angiogram a thin, flexible tube is inserted through an artery in the arm or groin to the heart. A special dye is passed through

the tube and, under x-ray, reveals whether any of the coronary arteries have become dangerously narrow and if any further treatment is necessary.) The nurse noted that the man wished to see the prison doctor before moving to the wing. In interview, she said that she would have referred him to the doctor in any case, because of the various concerns she had about him.

24. At 8.07pm, a doctor examined the man, with the nurse also present. The doctor wrote that the man's mood was low but that he had no suicidal thoughts. He recorded that the man had "multiple cuts" on his right arm (he made no mention of the cuts on the man's legs and ankles), which looked red, but not infected. He noted that the man had "self harm thoughts then but has repented and now no suicidal ideation". The doctor recorded that the man had "no acute medical issues now" but that his chest had felt "twingy" and tight earlier that day. The nurse took the man's blood pressure reading, which was high, and so the doctor telephoned the medical registrar at the local hospital who advised that the man be taken to hospital. The doctor prescribed amlodipine and valsartan and an antibiotic in case the cuts became infected.

25. At 8.30pm, at the doctor's request, staff called for an emergency ambulance to take the man to hospital, which arrived at 8.39pm. Prison staff completed a risk assessment, directing that the man be held in handcuffs while receiving treatment and be accompanied by three officers. The handcuffs could be removed with the authority of the duty governor and if the man's condition became life threatening. The SO said the level of restraints and the number of officers to accompany him to hospital were standard, given that the man had not been in prison at Manchester before and staff did not yet know the level of risk he posed. The ACCT document accompanied him to hospital.

26. The ambulance left the prison at 9.12pm, arriving at Manchester Royal Infirmary 12 minutes later. The man was taken to the cardiac catheter laboratory and was examined by a doctor at 9.30pm. Escorting staff recorded on the PER that the handcuffs had been removed after medical staff explained that the man was "one step away from being placed on a defibrillator" (a machine which delivers an electric shock to restart a heart that is not beating properly). Hospital staff carried out an angiogram, which was completed at 10.20pm. The man was then moved to a recovery room where two of the escorting officers talked to him. The officers were interviewed by GMP and the transcripts of those interviews were made available to the investigator.

27. One of the escorting officers remembered that the man said he had recently lost his job and was having problems with his partner. He said he had been suffering with depression. The man told the officer that he was worried about being in prison because he had heard that prisoners were often bullied. He was also concerned that other prisoners would be using drugs. The escorting officer knew that the man had not been in prison before. He also knew that he was on an ACCT and had cut himself before being arrested by the police. The officer was concerned that the man might try to harm himself again and so he tried to reassure him. He told the man that prison was not as bad as it seemed on television and that there were many procedures in place to keep prisoners safe. He said that the man became more relaxed and light hearted as a result.

28. The other escorting officer said that the man seemed low in mood after the angiogram. He told the officers that he had never harmed himself before and felt "stupid" to have done so. The two men began talking about fishing and, at this point, the officer said the man appeared more cheerful.

29. Neither officer recorded any of their conversations with the man in the ACCT On-going Record (which details staff interactions with the prisoner and any information which might be useful to other staff). In their interviews with GMP, both agreed that, in hindsight, they should have written about their conversations with him in the ACCT.

30. Hospital staff advised the officers that the man needed to remain horizontal for at least two hours and should be located in the prison's healthcare centre. He was discharged at 1.55am on 22 April and returned to the prison by ambulance, arriving at 2.15am.

31. On his return, the man was given a single cell in the healthcare inpatients unit. Initially, he was placed in a safer cell, which has fewer places a ligature can be attached to. (It seems that the man was not given a safer cell because staff were concerned that he might attempt to harm himself, but because the cell was empty when he arrived late that night. The following day he was moved to a different healthcare single cell, which was not a safer cell.) A healthcare officer took the man through the first night assessment and induction at 2.25am. In interview, the healthcare officer explained that the first night induction consists of a booklet with a number of tick box questions to be answered. Because the man had returned to the prison in the middle of the night and the prison was in "patrol state" (when the number of staff on duty is reduced and cell doors should only be unlocked in an emergency), he conducted the induction interview through the cell door hatch. The healthcare officer said it was unusual to conduct the induction interview at that time of night.

32. The healthcare officer recorded that it was the man's first time in prison. He noted that he suffered with high blood pressure, depression and insomnia, and had just returned from the hospital. The man was asked if he had any immediate concerns that needed to be addressed straightaway, and replied that he did not. He told the healthcare officer that he had harmed himself on 19 April, by cutting his wrist but that he did not currently feel like harming himself. In interview, the healthcare officer remembered that the man said the cuts had been "a mistake" and that "he'd put all that behind him now, all that's gone and he just wanted to get on". The officer noted that an ACCT plan had been opened earlier but that the man seemed calm. He recorded that he had no concerns about where the man should be located and that he was cheerful and co-operative during the interview. The healthcare officer explained the Listener scheme, use of the Samaritans' telephone and the cell bell to the man, and told him that "things would become clearer in the morning". (Each cell at Manchester is equipped with a cell bell, which alerts staff in an emergency.)

33. During the night, staff checked the man regularly. A registered mental health nurse was one of the nurses on duty and she was interviewed during the investigation. She explained that she and a colleague checked the man at regular intervals because he had just had an angiogram. She remembered that he slept well during the night. Overnight, the nurse updated the man's medical record noting that the angiogram had not identified any abnormalities. The man had been fitted with an angioseal in his groin (a device used to close the femoral artery after an angiogram) and the hospital had provided notes on the treatment this would require. The nurse indicated that the man should be reviewed by a doctor later that morning.

34. A nurse from the MHIT, made an entry in the medical record at 8.15am on 22 April. She noted that reception staff had referred the man for a mental health assessment but, because he was an inpatient in the healthcare centre, he would "not be assessed at this time". She concluded that he could be referred again if necessary once he was located on a wing.

35. The nurse from MHIT was also interviewed during the investigation. She explained that every day one member of the MHIT is responsible for checking referrals from reception. They look at the reasons for the referral and any medical history noted on the electronic medical record to decide how urgently the prisoner needs to be assessed. The nurse explained that a number of healthcare staff working on the inpatients unit are registered mental health nurses. In addition, an associate specialist in psychiatry and a consultant psychiatrist are available to inpatients every day. The nurse said that any of those staff are qualified to assess the mental health of patients located there. On that basis, inpatient prisoners are not assessed by the MHIT until or unless they are moved to a normal residential wing. (It appears that the man's mental health was not formally assessed before his death.)

36. At 8.30am, the man complained of "excruciating pain" at the site of his angiogram. A nurse examined the wound but found no evidence of bruising or swelling. She recorded that he had high blood pressure and said she would return to see him 15 minutes later. When she returned, the man said the pain was easing. The nurse saw the "multiple self harm lacerations" to his right arm, left calf and right ankle. She removed the dressings and noted that the wounds were healing well. The nurse was interviewed by the investigator. She remembered the man well as she had quite a lot of contact with him during his short time at the prison. The man told her he had cut his body while in the police cells. He said it was a "one-off" and "he had no intention of doing anything like that again". The nurse said the man caused her no concern that day and that, if he had, she would have raised them with any of the registered mental health nurses working on the inpatients unit at the time. The nurse told the man that the doctor would examine him later that morning.

37. A doctor assessed the man at 9.45am. He too found no evidence of bruising or swelling at the site of the angiogram, but noted that it was tender. He confirmed the prescriptions for the high blood pressure medications.

38. At some point that day, an Inpatients Care Plan was drawn up, detailing how the man's high blood pressure should be managed. While he remained an inpatient, staff were directed to ensure that he took his prescribed medication, and monitor the effect by taking his blood pressure twice a day. They encouraged the man to reduce his stress levels by talking to staff or accessing other available means of support. The man was told that he must inform staff immediately if he experienced a severe headache or chest pain. A second Care Plan, detailing how the man's angioseal should be monitored, was also devised. Staff were instructed to call 999 if the wound became swollen or bleeding.

39. At Manchester, newly arrived prisoners should be seen by a member of staff on their second day at the prison for the day two interview. During this interview, staff provide further information about life at the prison and can answer any of the prisoner's remaining questions or concerns. The man did not receive a day two interview and the healthcare officer explained this was because he was an inpatient. The officer said that staff on G wing, the induction wing, would complete the day two interview with prisoners. He said that G wing staff were supposed to come to the inpatients unit and continue the induction with prisoners there as necessary but that this did not often happen.

40. The man's ACCT assessment interview took place at 2.30pm, conducted by a healthcare senior officer, the inpatient manager. (During the assessment interview, a specially trained member of staff gathers more detailed information on the risk the prisoner poses to himself. The questions cover past acts of self harm, how the prisoner currently feels and what might be done to help them cope in prison.) The man told the healthcare SO that he "had not self-harmed for a while and that he has recently been under stress regarding court case and poor sleep pattern". In interview, the SO explained that he asked the man about his conviction for harassment. The man told him that he had been having problems with his partner, which had been sorted out. The SO noticed the cuts on the man's wrist, which he said he had made a couple of months previously. The SO had read the man's file prior to conducting the assessment and knew that the cuts were more recent.

41. The SO remembered that the man had seemed apprehensive about being in prison, particularly as it was his first time. However, the man was "lucid" and able to express himself, and according to the SO, was open and honest throughout. The SO thought that the man's primary concern was his insomnia. He told the investigator that the man was impatient for the assessment to end as he wanted to use the library. The SO took this as a good sign that the man was beginning to settle and was making plans for the future.

42. The SO recorded in the ACCT document that the man had no current thoughts of "suicide or depression", and that he was expecting his family and friends to visit him. He concluded:

> "The man appears a little anxious but no obvious signs of depression or mental illness. Good eye contact. No thoughts of hopelessness (asking to go to the library). No unusual thoughts or feelings. Answering all questions appropriately. No issues of addiction stated."

43. Forty minutes later, the SO (now acting as the ACCT case manager), a member of the chaplaincy team (who has since retired), two mental health nurses and the man met for the ACCT case review. The SO told the investigators that, wherever possible, ACCT reviews are multi-disciplinary. He said it was unusual for any member of staff to act as both the ACCT assessor and case manager but that, in some circumstances, it was the most efficient option. The SO recognised that it was "not ideal" for the same member of staff to fulfil both roles because getting a different perspective of the risk of self harm was helpful.

44. The SO recorded once more that the man had no thoughts of harming himself. He wrote that it was the man's first time in prison but that he was "settling ok". The man's main issue was "surrounding his sleep pattern" and he had no other immediate areas of concern. All present agreed that the ACCT should be closed. The post-closure review was due to take place on 29 April, in the meantime, the SO recorded that a routine referral had been made to the prison's associate psychiatrist. In interview, the SO said that he had referred the man to the psychiatrist for a mental health assessment and to consider the man's insomnia.

45. As part of the investigation, both the mental health nurses were interviewed. One of them said she saw her role in ACCT reviews as assessing the mental health of the prisoner, by reading the prisoner's file and asking them questions. The nurse had not met the man prior to the ACCT review. She knew he had been to hospital the previous night because of concerns about his blood pressure and chest pain. She also knew that he had made "superficial" cuts to himself before coming into prison. The nurse could not recall whether she knew it was his first time in prison.

46. During the review, she thought the man "seemed quite relaxed, he made good eye contact, was articulate, was happy to answer the questions, he just seemed fine". He was asked about the cuts he had made and said he had felt "frustrated". The nurse thought he seemed "embarrassed" about having harmed himself. The nurse explained to the investigator that a number of prisoners cut themselves or try to hurt themselves in other ways as a "coping strategy", but this does not necessarily mean they want to kill themselves. During the review, the man made no mention of any continuing desire to harm himself. The nurse also remembered that the man wanted to see the psychiatrist because he was having trouble sleeping (although he said he had slept well the previous night). She said he made no mention of wanting to be prescribed antidepressants. The nurse explained that his name was placed on the list to see the psychiatrist the following day.

47. The nurse was asked about the decision to close the ACCT. She said that all the staff present discussed whether they thought it should be closed or remain open. The nurse said she felt able to disagree with her colleagues if necessary and that all those present had to agree before an ACCT could be closed.

48. The second mental health nurse said that, before the ACCT review took place, the staff were briefed about the man and the reasons the ACCT had been opened. She also had no concerns about him during the review and explained that he seemed to be making plans for the future. She was content with the decision to

close the ACCT. The nurse said that, if staff present had been concerned about the man, the ACCT would have stayed open and the frequency of observations could have been increased. She said that, if anyone had concerns about his mental health, one of the mental health nurses on duty could have spent time talking to him.

49. According to prison records, the man attended a bible study group during the afternoon, held by the member of the chaplaincy team who had attended the ACCT review. As he has retired from the Prison Service, and no contact details were available, he was not interviewed as part of the investigation.

50. The nurse that saw him when he reported he was in terrible pain returned to take the man's blood pressure reading at 4.08pm. She noted that he still had high blood pressure but that he had been given his prescribed dose of amlodipine. The prison pharmacy did not have valsartan in stock, but it had been ordered and would be available the following day. The nurse wrote that the man had been to the library and out of his cell for a period of exercise. He asked the nurse if he could see the prison psychiatrist because he had not been prescribed his antidepressant medication. The nurse told him that he would see the psychiatrist the following day and the man was "happy with this". She concluded that he had no other concerns.

51. In interview, the nurse explained that the doctor who had examined the man that morning would not prescribe antidepressants unless it was an urgent request. Such prescriptions are normally made by the psychiatrist (who holds a clinic each weekday morning), following assessment of the patient's needs. She said that the man appeared happy to wait until the following day.

52. Later that evening, at about 8.00pm, the same nurse saw the man for what was to be the final time. He was returning to his cell after association (when prisoners are free to mix, use the telephones, play games, etc). The nurse asked him if he was okay, and he replied that he was going to "get his head down" for the night. The nurse had no concerns about him.

53. At 3.10am on 23 April, the registered mental health nurse who had been on duty the night before recorded that the man had raised no concerns during the night, and "appears to have slept well". She knew the ACCT document had been closed. During the night she checked him by looking through the observation hatch in the cell door and saw that he was sleeping.

54. In interview, the nurse explained that, at the beginning of the night shift, she was on duty in the inpatients unit with a registered general nurse. The registered general nurse was the emergency response nurse responsible for attending any health related emergencies across the prison. She was carrying the medical response radio. At about 4.30am, the registered general nurse had to leave the prison due to a family emergency. The registered mental health nurse took over the emergency response role and shortly afterwards was called to a fight between two prisoners on one of the main prison wings. She returned to the inpatients unit at about 5.40am and was in the staff office entering details of the fight on the electronic medical system.

55. At 5.47am, the healthcare officer who had conducted the induction interview was carrying out the roll check (when each prisoner is visibly checked and counted) of all the inpatient prisoners. The officer reached the man's cell, which was opposite the staff office. He looked through the observation hatch in the door and saw the man hanging from the cell window bars with a ligature made from a bed sheet around his neck. Both the registered mental health nurse and another officer were in the staff office and the healthcare officer called to them for help. The nurse used her radio to alert the night orderly officer (the most senior member of staff on duty and in charge of the prison overnight).

56. The officer broke open the sealed pouch containing the cell key and unlocked the man's cell door. (At night, members of staff carry a cell key in a sealed plastic pouch. When the prison is in patrol state, cell doors should only be opened in an emergency. If a member of staff opens their sealed pouch they must complete paperwork to account for their actions.) As he did so, the healthcare officer used the telephone in the office to ask staff in the control room to call for an ambulance, in line with the prison's contingency plans.

57. Both officers went into the cell and supported the man's weight. The nurse cut the ligature using her anti-ligature knife (a knife specially designed to safely cut ligatures, carried by all operational staff in the prison). The man was placed on the cell floor and the nurse checked for a pulse or any signs of breathing. Finding none, she and the officer began cardio pulmonary resuscitation (CPR), with the officer delivering the breaths and the nurse carrying out chest compressions.

58. The night orderly officer arrived at the man's cell very quickly, accompanied by the assist night orderly officer. As the nurse was upset, the night orderly officer took over chest compressions, while the officer continued to deliver breaths. In interview, the night orderly officer, the nurse and the officer said that they had not received updated basic life support training recently but felt confident about undertaking CPR. Although a defibrillator (a machine which can deliver electric shocks to restart the heart in certain circumstances) is available in the healthcare centre, the nurse said she was not confident about using one.

59. The ambulance arrived at the prison at 6.00am and the paramedics reached the man's cell at 6.06am. They carried out checks and at 6.10am, CPR was stopped and the paramedics pronounced that the man had died.

Contact with the man's family

60. At 11.15am, a member of staff from of the Safer Custody team and from the member of the chaplaincy team who had been present at the ACCT review arrived at the man's mother's house to break the news of his death to her and other members of the family who arrived shortly afterwards. They also offered the family members a visit to the prison to see the man's cell. The prison offered a financial contribution towards the cost of the man's funeral, which three members of staff, including the member of the chaplaincy team, attended.

Support for prisoners

61. Following the man's death, the night orderly officer instructed staff to check all the prisoners on ACCT documents. Case reviews were held with them all during the day. The Governor issued a notice to all prisoners informing them of the man's death and reminding them of the availability of the Samaritans and wing staff, if they needed support.

Support for staff

62. Staff who responded to the emergency and tried to resuscitate the man said that they had been well supported by the prison following his death. They were contacted by the prison's Care and Welfare Team and said they would know how to access further support if they needed it. Other staff who had contact with the man but were not present when he died also felt well supported.

63. However, according to Prison Service Order 2710 Follow up to a death in custody, a hot debrief must be held immediately after a prisoner has died. (Hot debriefs should be led by a senior member of prison staff and are intended to offer staff involved the opportunity to discuss the incident. The purpose is to offer reassurance, information and support.) A hot debrief was not held following the man's death.

ISSUES

The man's physical health needs

64. On his arrival at Manchester on 21 April, the man told the nurse that carried out his first reception health check that he had a history of high blood pressure, for which he was prescribed medication. He also said that he had undergone an angiogram recently. As a result of this and other concerns, the nurse referred him to the doctor who examined him a short while later.

65. The man told the doctor that his chest had felt tight and painful during the day. The doctor spoke to hospital staff who advised that the man be taken to hospital. An emergency ambulance was requested and the man spent several hours in hospital, undergoing another angiogram. He returned to the prison in the early hours of 22 April and was admitted to the healthcare centre, as advised by hospital staff.

66. Manchester PCT commissioned a doctor to review the clinical care the man received while in prison. The clinical reviewer concludes that healthcare staff correctly identified the man's presenting health problems. He notes that the man was transferred to hospital in a "timely manner" and, on his return, received appropriate care for his high blood pressure.

67. The clinical reviewer notes that the standard of record keeping was good and that the communication between healthcare staff in the prison and with external organisations was "efficient and effective". He concludes that the clinical care the man received for his physical health problems while at Manchester was equitable to what he could have expected in the community.

The man's mental health needs

68. While in reception, the man also admitted a history of depression and said he was prescribed antidepressants, which he had not been taking for several weeks. He told the nurse that carried out his initial health check that his community doctor had planned to change the prescription from citalopram to mirtazepine because he was having trouble sleeping. The man asked to be prescribed mirtazepine in prison. Healthcare staff interviewed said that prisoners' community doctors are asked to confirm existing prescriptions for antidepressants before a prisoner can be prescribed them in prison. Alternatively, the prisoner is assessed by the resident associate psychiatrist who prescribes medication as necessary. The man was due to see the psychiatrist the morning he died. The clinical reviewer agrees that this approach to prescribing antidepressants is appropriate.

69. Shortly before being arrested by the police, the man made a number of cuts to his arms, legs and ankles and escort staff opened a Suicide/Self Harm Warning Form. A number of discipline and healthcare staff who saw the cuts were interviewed and described them as superficial. However, as a result of his earlier behaviour, reception staff opened an ACCT plan. They noted that the man's mood was very low and he was suffering with depression and not sleeping well.

70. After carrying out the First Reception Healthscreen the nurse appropriately referred the man to the MHIT for assessment. However, the man was admitted as an inpatient on the healthcare centre following the angiogram. The nurse from MHIT explained that the MHIT do not carry out assessments on the inpatients unit. She said that, as a number of nursing staff working there are registered mental health nurses, they are equipped to conduct assessments themselves. She also said that the associate and consultant psychiatrists were both available to assess inpatients' mental health.

71. Mental health trained staff were present at the ACCT case review held on 22 April (and discussed in more detail below). In addition, the man was referred to the psychiatrist, and was due to see him on the day he died (albeit for his admitted problems sleeping rather than specifically for a mental health assessment). However, his mental health had not been formally assessed before his death.

72. The clinical reviewer notes that the man was observed by a number of different professionals while an inpatient, none of whom noted any significant problems with his demeanour, mood or behaviour. He concludes:

> "[T]he fact that a formal mental health assessment was not carried out … did not materially affect his care or treatment. He did not suffer a dis-benefit due to the fact that a mental health assessment was not carried out on him prior to his unexpected death."

73. However, the investigation highlighted some confusion between the MHIT and the inpatients unit staff about who should conduct a mental health assessment when the prisoner is an inpatient. This issue was raised with the Governor following staff interviews. The Governor responded by letter, confirming that "a review of the provision of services by [MHIT] has been undertaken" and as a result, he was "fully expectant that … there will be increased linkages and communication flows between the Healthcare Inpatients Unit and the [MHIT]". I have no doubt that, on receipt of this report, the Governor will wish to assure himself that improvements have been made.

Assessment, Care in Custody and Teamwork (ACCT)

74. The man was placed on ACCT monitoring while in reception on 21 April because he had harmed himself before being arrested by the police and said he suffered with depression. It was also his first time in prison. The officer who opened the ACCT noted that the man's mood was "low" and he had trouble sleeping. I believe that the decision to open the ACCT was appropriate.

75. Shortly after he arrived at Manchester, the man was taken to hospital. His ACCT plan accompanied him. Two of the officers who escorted the man told GMP that they had talked to him while at hospital. He told the officers he was anxious about being in prison and gave them more information about the problems he was facing in his personal life. Neither officer recorded the details of their conversations in the ACCT plan, although both told GMP they realised they should have done so. This further information about the man's state of mind might have helped inform

staff conducting the ACCT review the following day about the risk he posed to himself.

76. I recognise that, in the circumstances of carrying out the hospital bedwatch, the bedwatch officers unfortunately omitted to make a record of their conversations with the man. All the other contacts with staff were fully recorded and so I make no recommendation here. The Governor will wish to remind officers carrying out bedwatch duties that their interactions with prisoners at the hospital are just as significant as those which occur within the prison.

77. The following day, 22 April, the healthcare senior officer carried out the ACCT assessment interview and shortly afterwards, chaired the first case review, acting as case manager. He explained that it was unusual for the same member of staff to fulfil both roles, but that it sometimes occurred for efficiency reasons. The SO acknowledged that it was useful to have more than one person's perspective on the risk the prisoner posed to himself. While there is no specific guidance on this issue in Prison Service Order (PSO) 2700, Suicide Prevention and Self Harm Management, I do not think that one member of staff fulfilling both important roles is in keeping with the spirit of the ACCT process or that it maximises the prisoner's safety. I have discussed the issue with the Offender Safety, Rights and Responsibilities group (the department within the National Offender Management Service responsible for directing, amongst other things, the policies concerning the safety of prisoners). It is also their view that it is not best practice for the two roles to be fulfilled by the same person. The Governor may wish to consider this.

78. The ACCT case review held on 22 April was attended by a member of the chaplaincy team, two mental health nurses, the healthcare senior officer and the man. Those present knew that the man had recently made superficial cuts to his body, was prescribed antidepressants (which he had not been taking because he thought they were not working), had just returned from hospital and had never been in prison before. However, all those interviewed agreed that the man appeared calm and relaxed during the review, answering their questions openly and, apparently, honestly. The man told them that, until shortly before his arrest, he had never harmed himself. He said that his main concern was his difficulty sleeping and the healthcare senior officer referred him to the psychiatrist, who could explore the problem the following day. The man was keen to use the prison library and so staff thought he was settling into prison life and making plans for the future. The case review team were satisfied that he did not pose a risk to himself and, by agreement, the ACCT plan was closed.

79. Clearly, given that the man apparently took his own life within 24 hours of the ACCT plan being closed, that decision has been a key consideration for the investigation. Although being on ACCT plan will not, in itself, prevent an individual from attempting to take their life, it is an important mechanism in supporting them through a crisis. The man had been in the prison for less than a day and, as detailed above, there were a number of reasons to worry about him. The ACCT plan had not been open for long and staff had had little opportunity to get to know the man or understand the risk he posed to himself. However, the ACCT process is dependent on staff making sound judgements based on the evidence available to them (including conversations with the prisoner and other relevant factors). In

interview, the senior healthcare officer said that, in future, he would not close an ACCT plan until it had been open for at least 72 hours. I do not think it would be helpful to recommend a minimum period of time for which an ACCT should remain open. It is vital that staff continue to use their judgement to make decisions about prisoners' safety, taking into account all the available risk indicators. Nevertheless it is my view that it would have been prudent to have kept the ACCT plan open for longer.

80. The man's family asked why he was not being constantly observed at the time of his death. As part of the ACCT process, a decision to constantly observe a prisoner can be made when there are serious concerns that the prisoner intends to harm himself. As the man's ACCT plan had been closed, he was not subject to special monitoring at the time of his death. Although it will be of little comfort to his family, I do not think that, even if the ACCT plan had remained open, the level of risk staff thought the man posed to himself would have led them to constantly monitor him.

81. In the past, Manchester has been criticised for not having enough 'safer cells' available. (Safer cells are specially designed with fewer ligature points and furniture which cannot easily be broken. The design minimises the potential for self harm rather than removing it altogether.) According to a mandatory instruction in PSO 2700 "when considering where to locate an at-risk prisoner consideration must be given to whether the prisoner will benefit from allocation to a safer cell or other supportive location". There are nine safer cells in the inpatients unit. Manchester's local Suicide Prevention and Self Harm Management policy (dated July 2009) instructs that, in deciding where to locate a prisoner, staff should consider, amongst other factors:

    - "Health and mental health needs
    - The degree of risk and the level of support available
    - Where the individual can better be made to feel safe, comfortable and relaxed."

82. On his return from hospital, the man was given a safer cell in the inpatients unit because it was available, rather than because of the risk he was deemed to pose to himself. Later that day, he was moved to another cell on the unit, which was not a safer cell. On the evidence available, I do not think the man demonstrated such a risk to himself that he should have been placed in a safer cell. However, there is no indication on the ACCT plan that staff considered the best location for him. The Governor will wish to remind staff of this requirement in line with my earlier comment concerning recording important information in the ACCT plan. At the time of his death, the man was not on an ACCT plan and staff had no reason to believe he needed to be in a safer cell.

The induction interviews

83. The man arrived back at Manchester at 2.15am, following the angiogram. Having been allocated a cell on the inpatients unit, the healthcare officer completed the induction interview through the cell door observation hatch. Given that the man had never been in prison before, it was important that he was given some basic

information about life there. However, I am not sure that his best interests were served by the entire interview being completed at such a late hour and after a serious medical procedure. I appreciate this is a question of balance and that such situations arise infrequently. Because of that, I make no recommendation, but the Governor may wish to consider the issue and provide staff with guidance.

84. The healthcare officer told the investigator that newly arrived prisoners should undergo a day two interview, which provides the prisoner with further information about life in prison. However, he said that prisoners located in the inpatients unit often did not have a day two interview. He said that staff from G wing should visit the unit to complete the interviews but did not always do so. The day two interview provides staff with another opportunity to assess the prisoner's well being, and answer any questions or concerns they have. It is an important element of the induction process and on that basis I make the following recommendation:

The Governor should ensure that the day two interview is completed, regardless of where the prisoner is located.

The emergency response

85. While carrying out the roll check shortly before 6.00am on 23 April, the healthcare officer found the man hanging from the window bars in his cell. He alerted a registered mental health nurse and a officer, who were in the unit office, very close to the man's cell. The nurse used her radio to alert the night orderly officer while the officer used the cell key in his sealed pouch to unlock the door. The ligature was quickly cut and the nurse and the officer began CPR. The healthcare officer instructed staff in the control room to call for an ambulance. I am very pleased that staff responded so quickly and efficiently to the emergency. Their actions were in line with the prison's local contingency plans and I commend their attempts to resuscitate the man.

86. However, although the staff who responded felt confident beginning CPR, none could recall having recently received any refresher basic life support training (often known as Heartstart training). The nurse said that although a defibrillator was available on the unit, she did not feel confident to use one. The Governor, who was notified of the finding during the course of the investigation, confirmed that Heartstart training is delivered to all new staff during their induction. Refresher Heartstart training for all existing staff commenced in January 2010.

87. The head of healthcare confirmed that a rolling programme of refresher first aid training is in place for all healthcare staff and that this includes the use of defibrillators. I am pleased to be able to highlight this progress. However, I would advise the Governor and the head of healthcare that, until the programme has been delivered across the establishment, only those who have completed the refresher training undertake the roles of emergency response nurse and night orderly officer.

Support for staff

88. As noted earlier, PSO 2700 requires that a hot debrief be held shortly after a death in custody. There was no hot debrief following the man's death. The Governor was informed of the omission during the investigation and confirmed that a notice to staff reminding of the requirement had been issued.

CONCLUSION

89. The man had been at Manchester for less than 48 hours when he apparently took his own life. On his arrival, he told staff that he suffered with depression and had very recently made a number of cuts to his arms and legs. Staff opened an ACCT plan immediately. Shortly after his arrival at the prison, the man was taken to hospital and underwent an angiogram. He returned to the prison in the early hours of the morning and was given a cell on the inpatients unit. Later that day, the ACCT plan was closed as staff were satisfied that he posed no risk to himself.

90. Although I have reservations about the decision to close the ACCT and have identified some omissions in the care he received, I am pleased to note that the Governor has already acted on a number of these. I make one recommendation, but do not think that it would have prevented the man's death. I conclude that, although there were reasons to be concerned about him, his actions were not foreseeable.

RECOMMENDATION

1. The Governor should ensure that the day two interview is completed, regardless of where the prisoner is located.

   At the draft report stage, the National Offender Management Service accepted this recommendation, noting that "A review of the induction programme is to be undertaken to ensure that the two day interview is completed regardless of where a prisoner is located."