Investigation into the circumstances surrounding the death of a man in December 2009 at a hospital, while in the custody of HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

August 2011

This is the report of an investigation into the circumstances surrounding the death of a man while a prisoner at HMP Manchester. He was discovered hanging in his cell by staff in December 2009. He died in hospital 90 minutes later. He was 23 years old at the time of his death.

The investigation was conducted on my behalf by two investigators from my office. A clinical reviewer undertook a comprehensive review of the man's clinical care on behalf of NHS Manchester. Not for the first time, I am grateful to the clinical reviewer for his very valuable contribution. I apologise for the length of time it has taken to issue this report and the additional distress that has been caused.

The man served five years imprisonment in Scotland for the culpable homicide of his father. After his release on extended licence, he was twice recalled to prison, the second time to HMP Manchester after less than a day in the community. He was classified as a high-risk offender and was managed by a multi-agency panel which focussed on his risk to the public.

At Manchester he refused to follow the regime, preferring to remain in his cell almost all the time. He refused food and fluid for a while but eventually started to eat and drink, although he complained about the food. He did not accept that he was required to work and take part in sentence plan work with his offender supervisor. He told staff repeatedly that he would kill himself if they took his television away. It was decided that he did not warrant management through the national strategy for the most difficult prisoners. Instead, he was assessed by an Incentives and Earned Privileges Board. His privileges were reduced and his television was removed. The next day, disciplinary action was started after he refused to go to work. In the early hours of the following morning, staff found him hanging.

I make three recommendations, of which two have been accepted and the other partially accepted. Two cover the supervision of high risk offenders and the communication of decisions and advice to wing managers. I also endorse a recommendation made by HM Chief Inspector of Prisons relating to prisoners being punished twice for the same incident.

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

Thea Walton
Deputy Ombudsman **August 2011**

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SUMMARY

The man served five years imprisonment in Scotland for the culpable homicide of his father. He was released on extended licence and moved to approved premises in Manchester to be near his family. He was classified as a high risk offender and managed by a Multi Agency Public Protection Arrangements (MAPPA) panel.

The Parole Board of Scotland recalled him to prison for breaching his licence conditions and he spent almost 12 months in HMP Forest Bank. On 4 September 2009, he was released on licence and immediately breached several of the conditions. He was arrested the same day and taken to Manchester prison the following day.

In reception, the man told staff that he was not going to eat and drink and "would be dead within the week". Staff immediately opened a self-harm support plan to give him additional care. The support plan remained open throughout the three months at Manchester before he took his life. He also told staff that he would kill any prisoner with whom he had to share a cell. Staff assessed his risk to other prisoners as high and gave him a single cell. The man also told staff that, if his television was ever removed, he would "kill himself by hanging". He repeated this assertion on a number of occasions to various staff over the next three months.

While he refused food, the man was monitored daily by healthcare staff and the mental health nurse specialist. He refused to be examined by a doctor but accepted the visits by the nurses. Eventually he began to eat and drink regularly. The members of the MAPPA panel were concerned about the man's health and how it might affect the risk he posed. He refused to be assessed by a psychiatrist but did agree to a mental health assessment by a specialist nurse. She concluded that he had no psychotic symptoms but had some "depressive features". He refused to be referred to a doctor.

The man refused to attend work or education, which as a convicted prisoner he was obliged to do. He also refused to be involved with his sentence planning and offender supervisor. Once he began to accept food, staff started to deal with his refusal to accept his obligation to work or go to education.

In December, the wing manager decided to withdraw some of the man's privileges because he continued to refuse to work. His television was removed and the following day he was put on report for disobeying an order to attend work. At 1.30am the following morning, staff found the man hanging in his cell. They carried out cardiopulmonary resuscitation and called for an ambulance. In spite of their efforts and treatment by the paramedics, the man died shortly after being taken to the local hospital.

THE INVESTIGATION PROCESS

1. My office was notified of the man's death on 21 December 2009. The investigation was opened three days later when an Assistant Ombudsman visited the prison. He spoke to the Governor, saw the man's cell and collected his prison records. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact the investigator. There were no responses.

2. The investigators visited Manchester twice to interview staff. They also interviewed a number of staff at Forest Bank. They asked Manchester Primary Care Trust (PCT) to commission a review of the clinical care the man received at Manchester. The PCT appointed a clinical reviewer and he interviewed staff separately.

3. One of my family liaison officers contacted the man's family to ask if they had any questions or issues they wished to discuss. The family did not raise any questions at the opening stages of this investigation. However, their comments in response to the draft report are reflected at the end of this report.

HMP MANCHESTER

4. HMP Manchester is part of the National Offender Management Service (NOMS) high security estate. It is a complex local prison holding those remanded by the courts, prisoners convicted of serious offences and those serving a life sentence. The maximum prison capacity is 1,269 men. The prison was rebuilt in 1990 following a major disturbance.

5. Healthcare at Manchester is provided by Manchester Primary Care Trust. The most recent report published by HM Inspectorate of Prisons noted that there was evidence of strong support from the Primary Care Trust. This was demonstrated by an improvement to services and greater access to a range of prison and specialist clinics. Pharmacy and dental services were judged to have improved and there was efficient management of external appointments to clinical services.

6. The man did not attend healthcare clinics but had intensive contact with the prison specialist mental health nurse. Unlike other nursing and mental health professionals who are employed by the primary care trust, the specialist mental health nurse is employed by the prison and works independently of the Mental Health Inreach Team (MHIT). She receives referrals from all staff and assesses prisoners, making onward referrals to the MHIT for more complex cases.

7. The Independent Monitoring Board (IMB) comprises volunteers from the community. They monitor daily life in prison to ensure that decency is maintained, deal with prisoners' complaints and submit an annual report to the Secretary of State for Justice. The IMB annual report for Manchester for the period 1 March 2008 to 28 February 2010 raised a variety of general concerns. They include the high number of prisoners with severe mental health needs who are permanently accommodated on the inpatient healthcare unit during the lengthy process of transferring them to mental health units in the community.

8. HM Chief Inspector of Prisons regularly inspects all prisons in England and Wales. The latest inspection of Manchester was an announced inspection on 27 to 31 July 2009 and concluded,

> "Manchester has always tried to ensure that it can meet the needs of the great majority of its prisoners, who could be found in any large local prison, while ensuring the security necessary for category A prisoners. This inspection found that still to be the case."

The report then highlighted a number of areas that needed improvement as well as some examples of good practice. One concern is particularly relevant to this man,

> "We came across examples of prisoners receiving a punishment following adjudication and being placed on basic shortly thereafter. The policy stated that any prisoner found guilty of a single 'serious offence'

would be subject to a review board; staff and prisoners felt that this process was a formality, and that downgrades were automatic."

The report recommended, "Prisoners should not receive a punishment on adjudication and then be placed on basic for the same incident."

9. The man's death is one of 31 to have occurred at Manchester since April 2004, when this office began investigating all deaths in prison custody in England and Wales. Twelve of the previous deaths were due to natural causes. None of the issues in the investigations into the recent self-inflicted deaths shared similar circumstances with the man's death.

10. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan is drawn up for the most serious offenders and benefits from the information, skills and resources provided by the individual agencies co-ordinated through MAPPA. There are three levels:

> "Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.
>
> "Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
>
> "Level three - Anyone subject to level three is considered as being the highest risk, where more than one agency will take responsibility for the management of the person concerned."

11. The Incentives and Earned Privileges Scheme (IEP) was introduced in 1996 to encourage and reward good behaviour in prisons. Governors have devolved responsibility to draw up their own schemes however the scheme must operate on at least three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour and performance. The key earnable privileges/incentives are: extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association. In addition to the key earnable privileges, prisons may make other privileges and incentives available to suitable prisoners according to local circumstances.

KEY EVENTS

12. In 2004, the man who died pleaded guilty to the culpable homicide of his father. He was sentenced to five years custody with a four year extended licence, (a longer than normal period). A plea of culpable homicide was accepted on the basis of the man's diminished responsibility at the time of the offence. The court accepted that he was suffering from a moderately severe depressive illness with some paranoid thoughts at the time. He had no previous convictions and was 17 years old when he killed his father.

13. A psychiatric report prepared for court said that the man had harmed himself while living at home by making cuts to his stomach and arms. A supplementary report says that the man explained his self-harm as a response to things he heard on the news and his depression.

14. In 2005, the man was eligible to apply for release on parole licence. However, he chose not to do so as he believed that he did not deserve to be released as he had not spent enough time in prison or suffered enough punishment. On 15 March 2007, he was released on licence (he was not on parole). He asked to resettle in Manchester and this was agreed. He was assessed by the local Multi-Agency Public Protection Arrangements panel as a level 3 offender who posed a very high risk of harm to the public.

15. One of the conditions of the man's licence was that he live at approved premises. Approved premises (formerly known as probation or bail hostels) provide controlled accommodation for offenders under the supervision of the Probation Service. They are usually ex-prisoners on licence in the community who have been assessed as requiring a greater degree of supervision than is possible in other forms of housing. The level of supervision is intended to reduce the risk of harm to the public. Residents follow a structured regime, which includes an overnight curfew. There is 24 hour staff supervision.

16. After being released, the man had contact with his family which was approved by the Probation Service. He attended college between September 2007 and June 2008 and had a positive academic report. He studied for a national award in sport and obtained the equivalent qualification to an A level.

17. Another licence condition was that he was required to attend a local adult forensic mental health unit. A clinical psychologist became involved in his treatment. His opinion was that the man was suffering from an undiagnosed paranoid illness at the time of the offence with an expectation of relapses over the course of his lifetime. He noted that the man had little idea of his current mental state, the impact the offence had on others or the risk he posed regarding his future behaviour.

18. After 18 months in the community, the man was recalled to custody on 11 September 2008 for breaching the conditions of his licence and taken to HMP Forest Bank. (Once released on licence, a prisoner can be recalled to prison at any time if they breach their licence. The Parole Board will consider the details

of the breach and make a recommendation to the Secretary of State on whom the final decision rests.) While living at the approved premises, the man:

- Failed to disclose that he had formed a relationship with a member of the premises staff.
- Failed to disclose information regarding his movements and circumstances to staff.
- Exhibited unacceptable behaviour to fellow residents.

19. The Parole Board decided to release the man on licence again as the offender management professionals considered that his behaviour was manageable in the community. He had a robust release support plan, including accommodation in approved premises in the West Midlands, under the supervision of the West Midlands Probation Area (now Trust) for a six month period.

20. On 4 September, the man was released on licence. Just before he left the prison, staff assessed him as being in a very vulnerable and erratic state and their attempts to calm him down had failed.

21. Part of the lengthy licence release conditions for the man's release from Forest Bank and his supervision in the community were that he had to comply with transportation arrangements made by the Probation Service. On the day of his release he would be met at the prison by his probation officer together with a police officer involved with the MAPPA team and driven to the approved premises. He was also not to contact his ex-girlfriend without prior permission.

22. The man breached conditions 3, 15 and 17 of his licence by failing to keep in touch with his supervising officer and refusing to be escorted to the approved premises. A report considered later by the MAPPA panel stated that his probation officer made determined attempts to persuade him to get into the car. The report also described how a male member of staff from the approved premises was present at the prison gate and persuaded the man not to travel with his probation officer. A letter to revoke the man's licence was sent to Greater Manchester Police for his immediate arrest and recall to prison the same day. During his arrest, he committed an act of criminal damage by breaking a light belonging to Manchester City Police.

23. The man's residential unit manager at Forest Bank saw him on the day he was released. She told the investigators that, as she was coming down the hill to work at the prison in the morning, she saw the man walking up the hill with his bag. She thought that his conditions were that he was to be collected by the police and that the prison might have committed a procedural error and released him before the police had arrived. In order to clarify the matter, she said she went to the community protection unit at the prison and told them what she had seen. The prison were unaware of what had happened and the community protection unit contacted the senior seconded probation officer in the prison to explain the position. The residential unit manager was told that the man had refused to go with the police and had told them that he would be dead the next time they saw him.

24. The man told the police officers who arrested him that he intended to kill himself. A doctor who examined him in the police station concluded, “Relaxed, not distressed in any way, lucid and co-operative. Mentally he is fully compos mentis”. The doctor advised that he should be checked every half hour. However, the Suicide/Self-harm Warning Form completed by the police showed “states that he will not eat or drink anything and seems depressed”. It was also recorded, “Also had knife concealed on his person”.

5 September 2009, the man arrives at HMP Manchester

25. The man was received into HMP Manchester on 5 September 2009. He was listed on the Violent Offender & Sex Offender Register (ViSOR). (ViSOR is a UK-wide system used to store and share information and intelligence on individuals identified as posing a risk of serious harm to the public.) On arrival at the prison, he went through the usual reception process.

26. A nurse interviewed the man in reception. She wrote in his medical record that he told her:

> “His plans had not worked out. … His intention was to go to visit his ex-partner and then kill himself, but she did not want his death on her conscience so she had called the police. Further stated on interview that he would refuse food and fluids and ‘be dead within the week’ – went on to deny any self-harm ideation as he did not feel that starving himself is self-harm.”

27. The nurse referred the man to the Mental Health In-reach Team (MHIT) and asked for a registered mental nurse (RMN) to assess him in reception. She also put in place monitoring under the suicide prevention and self-harm management measures by opening an Assessment, Care in Custody and Teamwork (ACCT) plan. (ACCT has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is subject to regular case reviews that will decide on the level of observations/conversations to be carried out at intervals which are determined by the perceived level of risk. The observations continue during the day and the night.)

28. The nurse completed the Concern and Keep Safe section of the ACCT document at 2.15pm. She repeated the information in his medical record, adding the opinion “very immature”. On the page highlighting triggers and warning signs that would prompt an immediate review, she wrote that the man had replied “Taking my TV off me”.

29. Just over an hour later, two RMNs attended reception and interviewed the man. He repeated that he would starve himself and die in a week. When asked if he had any thoughts of harming himself in any other way, he said that he did not as he wished to die in a “dignified way”. He told them that, until being at Forest Bank, he had not had contact with mental health services. A psychiatrist at the prison had completed a psychiatric report for the court. The man said that the

psychiatrist's report "stated that he did not have any mental health problems or conditions". When asked about family, he said that, by his own choice, he did not have any contact with them.

30. When a prison manager interviewed the man to complete the Cell Sharing Risk Assessment, the man told him that "He doesn't do well with others" and spoke of other prisoners in a derogatory way. Every prisoner is subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account the situational context of any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a plan to minimise risk for those identified as high or medium risk which is reviewed at regular intervals.

31. The man told the prison manager that he would kill his cell mate if he had to share a cell. Staff decided to put him in a single cell because of the high risk he presented to other prisoners. A note in his records states that this precaution extended to Listeners. (Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.) Staff noted that he had cut his left arm.

32. The prison manager also noted that the Incentives and Earned Privileges (IEP) scheme should be used to manage the man's anti-social behaviour. IEP was introduced in 1996 to encourage and reward good behaviour in prisons. Governors have devolved responsibility to draw up their own schemes however the scheme must operate on at least three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour and performance. The key earnable privileges/incentives are: extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association.

33. However the man's behaviour had changed by the time of his first night in prison interview with a senior officer (SO). The SO wrote in the record that he was "chatty with good eye contact" and "appeared to be a very deep thinking person". She made a referral to the MHIT to assess his mental state. The wing induction unit notes showed that he declined a telephone call to his girlfriend, saying that she had hung up on him when he contacted her while he was in police custody. However, an entry in the ACCT notes, "His ex-partner was contacted to re-assure her he was OK."

34. The senior officer also completed the ACCT Immediate Action Plan, listing a number of actions in addition to putting him in a single cell and contacting his ex-partner. The use of the dedicated Samaritans phone was explained and staff told him that he could use it whenever he wanted to. This was especially important as, because of his threats towards other prisoners, the staff would not allow Listeners to go into his cell. The senior officer also set the level of staff observation of the man at five times per hour during the night. She

instructed staff that, if the man was awake, staff should "explore [his] thoughts" with him. During the day, staff were to have a minimum of four conversations with him.

35. The following day (6 September), an officer carried out the ACCT assessment by interviewing the man. He noted that the man said he would kill himself by starvation as he "cannot cope" with being in prison again. He also noted:

> "He feels due to his record he has no future, he will be unable to gain employment or lead a 'normal' sort of life due to probation, social services involvement with himself. … He is extreme in his views and feels people have 'betrayed him'."

36. When asked about his reasons for living, the man said that one was "seeing his now ex-partner", adding that social services had interfered with this. He then said that in prison he would, "sleep, sit and watch TV … refuse to go to work but … he could not cope with not having a TV". He denied being mentally unwell, stating that he did "not fit in with society".

37. At the ACCT review two hours later, a senior officer, an officer and the man met and discussed his actions and feelings. They decided that a member of the MHIT should be present at the next review, which was set for either 10 or 11 September (the date is unclear in the record). The ACCT Care and Management Plan (Caremap) focussed on encouraging the man to start taking food and fluid and the assessment by the MHIT staff. However, he continued to refuse food and drink.

38. On 7 September, the man appeared in court, where he was given a three month conditional discharge for the criminal damage offence. On his return to the prison, the same senior officer and officer interviewed him and tried to persuade him to begin taking food and fluids, without success. The officer wrote in the wing history sheet that the man appeared "unwilling to see or consider anyone else's views, ideas or feelings".

39. The following day, the prison's mental health nurse specialist interviewed the man, along with a further nurse. The mental health nurse specialist told my investigators that the man refused to allow her to carry out a mental health assessment on him. However, she noted in his medical record that he "… did not present as depressed or exhibiting any acute psychotic phenomena". The man told her that he was refusing food for two reasons: to "punish his ex-girlfriend and a friend who contacted the police" and to "prove to the higher powers in prison that he … doesn't care about anything".

40. Later that day, there was a multi-agency case conference to discuss procedures for the man's continued refusal of food. At first, he refused to attend the meeting, saying he "couldn't be bothered to talk about it any more". However, an officer persuaded him to attend. The man showed little interest and would not accept when medical intervention was needed. He said that it was "his choice to die" and he would not attend appointments with the doctor. The officer noted that he would not be persuaded otherwise and was not

confident that he would comply with monitoring or treatment as or when his health deteriorated.

41. The staff at the meeting decided that the mental health nurse specialist would visit the man each day to offer medical advice and try to persuade him to resume eating and drinking. A full review meeting was then scheduled for 14 September.

42. On 9 September, the duty wing SO made an entry in the wing history sheet, warning staff to be aware that the man was "capable of trying to coherse (sic) or manipulate staff to his advantage".

43. Over the next few days, nurses and discipline staff monitored the man closely. Sometimes he refused to speak but at other times he would talk and laugh with the staff. On several occasions, he said that he would eat if staff "got him a KFC [Kentucky Fried Chicken] bucket". He also refused to accept a doctor's appointment or give urine and blood samples that would have allowed healthcare staff to gain an accurate picture of his physical health.

44. While the man was in prison, the overall responsibility for creating and managing his sentence plan and potential release arrangements remained with his community based offender manager (formerly known as probation officers). Day to day liaison with the man and his community based offender manager and implementation of the sentence plan was the responsibility of an officer who was an offender supervisor and a discipline officer. The man was assessed as a high risk of harm to the public and to specific individuals. He was designated at MAPPA level 3, Tier 4, which is the highest risk of offender supervised by the National Probation Service.

45. Prison records show that the offender supervisor and discipline officer visited the man in his cell on the wing on a number of occasions and attempted to engage with him, but he was not interested. The man knew that he had a release date and that following his release from prison, he would not be on licence to the Probation Service. He would be free to live and do as he pleased without restrictive conditions.

46. Either the prison's mental health nurse specialist or another member of the MHIT visited the man each day, usually accompanied by a registered general nurse (RGN) who assessed his physical health. The staff saw no signs of dehydration in the man, although he continued to say that he was not eating or drinking. The mental health nurse specialist told my investigator that on 14 September, when she challenged him about his food intake, he shouted at her and argued. He had already received warnings about unacceptable behaviour towards staff, and was given a written warning by the wing manager on this occasion.

47. At the health review that afternoon, the mental health nurse specialist concluded that she could not offer any therapeutic interventions but would continue to attend case reviews. She wrote in the medical record, "… his behaviour seems to be more anti-social and a matter of discipline at this time".

The man returned to his cell and refused to leave it, including the following day. The senior officer who had conducted the man's first night in prison interview noted in the ACCT plan that he then threatened to hang himself if staff removed his television.

48. The offender supervisor and discipline officer spoke to the man on the morning of 15 September and again discussed his refusal to become involved in the sentence management process. The officer noted in the ACCT plan that the man said in response that "He did not intend ever to leave prison and so the process was of no use to him." Throughout his time at Manchester prison, he refused to attend work or education as well as refusing to cooperate with his offender supervisor.

49. The man did not attend the ACCT case review later that morning. During the review, staff received a telephone call from the man's ex-partner, expressing concern that he had not contacted her. When the senior officer who had conducted the man's first night in prison interview passed on the message, she noted that it appeared to lift the man's mood slightly. The man said that he had written to her, enclosing a visiting order and, although not expecting her to visit, he did think that she would write to him. In the notes of the review, the senior officer also wrote that the man had given her a canteen order sheet, in which he had ordered flavoured milk and drinking chocolate.

50. On 16 September, the offender supervisor and discipline officer attended a MAPPA meeting held in the community with other medical and criminal justice professionals involved in the man's care. He updated the meeting regarding the man's lack of progress and the deterioration in his mental health in prison. The man's community based offender manager was present at the meeting and said that the psychiatrist and clinical psychologist, who knew the man, had offered to assess him. The outcome of the meeting was that the MAPPA panel requested an urgent assessment of the man's mental state in order to assess his risk. The high level of concern was demonstrated by the psychiatrist giving the offender supervisor and discipline officer his contact details so that the prison could contact him if they needed any assistance to undertake the assessment.

51. The following day, a nurse noted in the man's medical record that he was now drinking milkshakes. He told her that he felt "so-so" and intended to continue eating.

52. The managers of G wing then decided to move the man from the Induction Unit to one of the normal accommodation wings. Most prisoners move from the Induction Unit after completing the induction process but he had been kept on the unit for longer. An ACCT case review was held on 18 September, attended by the man and managers from both G wing and K wing, his new unit. The senior officer who had conducted the man's first night in prison interview wrote in the notes that he was "happy to relocate", which he did at 3.00pm. Staff assigned cell K-22, another single cell, to the man as it was the closest one to the wing office, allowing them to monitor him as they went to and from the

office. The ACCT monitoring and support for the man continued at the same level of frequency.

53. At the next ACCT review a week later the duty wing manager noted that the man still maintained that he was refusing food. However, he had ordered food on his canteen order form and had eaten the previous evening's meal. The man said that he was not prepared to discuss his issues, saying that he had "given up caring".

54. The ACCT review on 2 October discussed the man's refusal to eat during the previous five days. He said that it was the way he intended to end his life. However, he then said that he would be eating fish and chips for dinner that evening as it was something which he enjoyed. The mental health nurse specialist again asked if he would accept a doctor's appointment to discuss his refusal of treatment. He refused because the appointment might be arranged for 9.00am, a time which he was unwilling to accept.

55. Three days later, the mental health nurse specialist was passed a letter from the chairman of the MAPPA panel to the prison Governor, asking for an urgent psychiatric assessment of the man. The members of the panel were concerned that they could not assess the risk which he posed to the public and wanted a psychiatric report to better inform them. When the mental health nurse specialist raised the issue with the man two days later, he refused to be assessed by a psychiatrist. However, he did agree to the mental health nurse specialist assessing him.

56. The mental health nurse specialist met the man on 9 October for the assessment. She noted in the medical record that he "did not display any psychotic phenomena, he has some depressive features". The man told her that he cut himself for about a year when he was 15 years old. He stopped because he could not see any reason to continue. At the age of 16, he tried to hang himself but failed. The mental health nurse specialist considered that his periodic food refusal was a form of self-harm, replacing the earlier cutting. He said that his problems were the result of the prison, MAPPA and his ex-girlfriend. He refused to see any doctors but agreed to the mental health nurse specialist monitoring him on the wing. She wrote to the chairman of the MAPPA panel, informing him of her assessment.

57. The mental health nurse specialist next spoke to the man four days later. He told her that he had had a visit from his ex-girlfriend which had gone well. However, he had said goodbye to her and told her that he did not want to see her again. He told the mental health nurse specialist that he was "fed up all the time and just wishes it was all over".

58. On 20 October, the man received another warning from a senior officer after failing to leave his cell during a fire evacuation practice. He told the mental health nurse specialist that he was very angry about this. He again said that if his television was removed, he would hang himself.

59. The entry in the medical record concluded:

> "[The man's] mood remains unchanged. He is not expressing intent to harm himself at this time, however his behaviour is clearly manipulative, I have advised the wing staff that Senior management should be involved in any decision in regard to further disciplinary procedures."

60. From this, it would appear that the mental health nurse specialist did not regard the man's (repeated) assertion that if his television were removed he would hang himself as an intention to self-harm. The entry appears to regard this statement as "manipulative behaviour".

61. For the next few days, the wing staff noticed an improvement in the man's behaviour and he began to eat some meals once more. During the ACCT case review on 23 October, he talked about taking his life, but also about being released with no licence conditions in 2012. He still refused to work or to cooperate with his offender supervisor. A senior officer, who chaired the review, reminded the man of the consequences of not engaging with his sentence plan. In a report for the Managing Challenging Behaviour Strategy (MCBS) group dated 6 December, the senior officer wrote that during this case review he told the man that:

> "At this present time the focus of his management is on his on and off food refusal but the issue of sentence management will be addressed at a later stage and is not going away as no engagement with his offender supervisor will result in him being reduced in level of regime to basic."

The senior officer noted that he explained this to the man to "ensure no surprises if he continues not to engage with OMU (Offender Management Unit)".

62. On 2 November, the senior officer who chaired the review on 23 October gave the man his parole dossier to prepare for the hearing which was due to take place on 14 December. The man later told the offender supervisor and discipline officer that he was not interested in the parole hearing as he would not be released. He did not plan to attend.

63. The next ACCT case review was held on 5 November, two weeks earlier than planned. This was because all the prisoners with open ACCT plans were reviewed after another prisoner died, to assess whether they needed additional support. The man stated robustly that he had not been affected by the death of the other prisoner. Staff had found two suicide letters in the man's cell and discussed them at the review. The man said that he did not intend to send them but writing them had been a way of "articulating his feelings".

64. On 11 November, the MAPPA panel met again to discuss the man. The members highlighted a number of concerns about his behaviour in prison and possible issues on his release. They were concerned that his "risk has increased as his health has deteriorated" and described his current behaviour

as unpredictable. The panel decided to ask the offender supervisor and discipline officer to liaise with the mental health nurse specialist to arrange for the man to be admitted to the prison's healthcare centre. The man would then be offered an appointment with a psychiatrist or psychologist from the Forensic Personality Disorder Assessment and Liaison Team (Edenfield Centre) who had assessed him previously. However, this did not happen. When my investigators spoke to the mental health nurse specialist, she was adamant that the man would not cooperate with anyone from the Edenfield Centre. He had read reports which they had compiled on him in the past and had been very angry at the contents. She said,

> "… he was also very aggrieved about his experience of Edenfield assessments .., because he'd seen the reports and he'd read all that … his attitude towards [the psychiatrist], this is what he'd mentioned, he'd seen those reports, this is why he didn't want to talk about it."

65. On the afternoon of the same day, there was a meeting of the public protection unit within the prison. The man's behaviour was discussed. Staff decided to refer him to the Managing Challenging Behaviour Strategy (MCBS) group because of his refusal to engage in his sentence plan and failure to attend work or education. (The MCBS is a national strategy for managing some of the more difficult prisoners within the high security prisons.)

66. The next ACCT case review was held on 26 November. The man told the staff that he did not feel suicidal but then said that he would eventually kill himself in prison or after release. He also said that there was "no-one who he wants to know" about his eventual death. He then told staff that he did not want to talk to them unless they "get him a KFC". The mental health nurse specialist wrote in the medical record that during the review the man, "Currently is denying any suicidal ideation or intention, however again stated that if placed on basic regime he will harm himself!" The next review was scheduled for 22 December.

67. A week later, the SO who had chaired the review on 23 October completed a report for the MCBS for the man. He noted that he had started to engage with healthcare and MHIT staff and had been collecting his meals for several weeks. He listed three possible triggers which could mean that the man's behaviour might deteriorate – the removal of his television, sharing a cell and engagement with the offender management process. He also summarised the man's self-harm and statements to take his life, referring to them as "threats".

68. Neither the SO or the wing manager went to the MCBS meeting on 10 December. The offender supervisor and discipline officer and the mental health nurse specialist attended as they had referred the man to the meeting. Afterwards the mental health nurse specialist passed on the board's decision verbally to the two managers. The minutes of the meeting state that the man was not a suitable candidate for the MCBS. Staff were advised to manage him by other means - through anti-social behaviour measures, behaviour compact or the IEP system. However, a separate document called the Record of Local Establishment Panel stated that the man should be managed using the IEP

system, with the involvement of the safer prisons team. At interview, the wing manager said that the mental health nurse specialist said that the decision was for the man to be managed through the IEP system. The SO who chaired the review on 23 October said the same but, when asked, thought that he recalled mention of behaviour compacts.

69. The staff began the process of arranging an IEP board to manage the man's refusal to work with his offender supervisor and failure to attend work or education. The board met on 17 December, chaired by the wing manager and attended by the SO who had chaired the review on 23 October and the mental health nurse specialist. The wing manager told my investigators that, when he asked the man why he was there, he replied that it was "to go onto basic". The wing manager explained the IEP system and told him that, if he agreed to work with his offender manager and attend work or education, he could remain on standard level. He refused, saying that, as he had been sentenced by a Scottish court, the rule that all sentenced prisoners must work did not apply to him. He also said that in 2012 he would be released, free of any licence conditions. The wing manager told the man that if he refused to attend work, he would be placed on report (breach of discipline) and the adjudication would be held by an independent adjudicator. (An adjudication is an internal hearing into breaches of prison discipline.)

70. The wing manager then asked how the man thought that he would cope when his television was removed. The man said that he would manage without it, as it was not "his world". The wing manager told my investigators that he thought that this was not just a stance but that the man really did not need his television. He then told the man that he was putting him on the basic regime for a period of seven days, after which there would be a review. He advised him that he could appeal against the decision. The man said that he would not appeal as he agreed with the reason for being placed on basic regime.

71. An ACCT review was held after the IEP board. The SO who had chaired the review on 23 October chaired the meeting and the wing manager, the mental health nurse specialist and a wing officer were there as well. The SO wrote that the man accepted that his behaviour did not meet the criteria for standard level but "he is happy to remain in prison until 2012". The next ACCT review was arranged for 23 December. The mental health nurse specialist wrote in the medical record that the man did not say that he would kill himself if the television was removed. She recorded that the levels of observation were increased (to four conversations during the day and five observations at night) which she told the safer custody manager about. After the review, staff moved the man into cell K 3-1 which is close to where the officer on night duty is based. The cell did not have a television and he was on his own.

72. The following morning, at 7.50 am, an officer told the man to report for work in Workshop 1. The man refused, and so the officer placed him on report. The man said that he understood the adjudication process and "he did not care".

Events of the evening before the man's death

73. The weekend regime for staff and prisoners differs from the weekday routine. The final meal of the day is served at 4.45pm. A last count of prisoners (the roll check) is at 9.00pm. The day staff go off duty and night staff are in place. The man was locked in his cell for the night as were the other prisoners.

74. The ACCT document on-going record shows that an officer spoke with the man at 7.00pm. He was lying on his bed with the light on and awake. An officer made an entry at 8.15pm in the ACCT document. The officer asked the man how he was managing without a television. He responded by making a derogatory comment about the standard of television programmes. He then complained about the officer checking on him during night. The officer explained that he had a duty of care to make sure he was alright. The man was said to have responded by laughing and the officer noted that he did not have any concerns at this time. A further officer checked on the man at 11.30pm when he appeared to be asleep on his back and movement was noted.

Events in the early hours of the man's death

75. In his statement, which was written after the man died, the officer who had earlier checked on the man at 11.30pm said that at 1.30am he was carrying out the wing check including observations of three prisoners, including the man, who were subject to ACCT monitoring. The officer arrived at cell K3-1 and switched on the night light. The man was partially visible, sitting on the large hot water and heating pipes at the back of the cell. The officer tapped on the cell door and shouted to the man, but did not get a response. He ran along the landing and shouted to two officers on H wing to come to the cell to help him.

76. All three officers went to the cell and one of them looked through the observation hatch in the door. He shouted the man's name but did not get a response. He told the officer who had checked on the man at 11.30 pm to call for medical assistance and the other officer to get her cut-down tool ready. (Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners must carry their own personal issue tool when they are on duty.) The control room log showed the time of the call as 1.35am. He broke the seal on sealed key pouch he was carrying, removed the cell key and opened the door.

77. The female officer saw that the man was suspended from the window bars with a piece of ripped bedding. She noted that he had tied his hands and feet together. She passed her cut-down tool to the officer who had earlier looked through the observation hatch in the door so he could cut the man down. At this point, a further officer came into the cell. The three officers who had originally entered the cell placed the man on the floor. The female officer confirmed that the officer who came after them checked for a pulse in his neck and wrist. She said that they were speaking to him all the time to "try to establish if he was coherent". She left the cell when a nurse started cardio

pulmonary resuscitation (CPR) with the officer who had arrived after the original three officers.

78. The officer who was assisting with CPR wrote in his statement that at around 1.30am he heard a call over the radio net for Oscar 1 (the most senior officer on night duty) to come to K wing. He went to the cell to assist and found two officers cutting the man down. He said he helped lay the man on the floor. He checked his right wrist for a pulse and his airways for signs of breathing but could find no evidence of either. At this point, a registered general nurse arrived to help the officer carry out CPR. They gave 30 compressions to two breaths and carried on until the paramedics arrived at the cell at about 1.50am. He left the cell to allow paramedics to continue care.

79. The registered general nurse was in healthcare with a registered mental nurse when she heard a garbled message over the radio net. She heard the word "hanging" and immediately went with the registered mental nurse to the wing. She described arriving on K wing very quickly. She saw the man lying in the middle of the floor near the window. She said that she knew he was dead, but she started CPR with the officer. She made an airway and took out her pocket mask and used it on the man.

80. Once on K wing, the registered mental nurse went to the store cupboard where the emergency equipment bags and the defibrillator were kept, only to find them missing. He went to the I wing treatment room instead, going through four sets of locked gates to get there. He retrieved the two equipment bags which he took to the registered general nurse. In interview with the investigators, the registered general nurse said that she then asked him to fetch a defibrillator. To save time, the registered mental nurse radioed his colleague in the healthcare centre to meet him at the door with the defibrillator. The registered mental nurse collected it and returned to the cell with the equipment. The registered general nurse attached the defibrillator to the man and the machine instructed staff to continue with CPR. She and the officer continued doing 30 compressions to two breaths until the paramedics arrived at the cell at about 1.50am. The officer then left the cell to allow paramedics to continue care.

81. The paramedics transferred the man to the ambulance and two officers accompanied him to outside hospital. They left the prison at 2.35am and arrived at the Accident and Emergency Department ten minutes later. At 2.49am, a hospital doctor told the officers that the man had died.

82. The staff who tried to resuscitate the man attended a hot debrief before ending their shift. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. Several of the staff told my investigators that they found it useful to be able to hear from each person what had happened. The principal officer in charge of the prison commended the staff for their actions. The staff were also offered the additional support from the Care Team.

83. Later that morning, the duty governor and one of the prison chaplains went to the home of the man's former girlfriend to break the news to her. The man had named her as his next of kin when he arrived at Manchester. Afterwards, the family liaison officer spoke to the man's mother and arranged to visit her and her daughter two days later.

ISSUES

Clinical care

84. A review of the man's clinical care was undertaken by a clinical reviewer on behalf of NHS Manchester. His review is based on clinical notes, prison records, including ACCT records and interviews with prison staff. The clinical reviewer has judged that while the man's death was foreseeable, it was not predictable or preventable. He concludes that the clinical care and treatment that the man received at Manchester was of an adequate standard.

85. The clinical reviewer concludes that the healthcare staff at the prison acted appropriately in their dealings with the MAPPA panel. He noted:

> "The healthcare at HMP Manchester took appropriate note of concerns and took appropriate action. [The man] did have a mental health assessment albeit not by a consultant. The action taken by MAPPA and the letter from the forensic psychiatrist demonstrates that the whole system approach to risk management operated effectively in this case. In this context it should be noted that [the man] had refused to see a general practitioner or a psychiatrist."

86. Related to this is his opinion of the mental health assessment carried out by the mental health nurse specialist. He concludes that the assessment was reliable and could be safely be used to decide how to treat the man. The clinical reviewer commented that:

> "… in general [the man] adopted a negative stance towards the prison staff including healthcare staff. However it appears that [the mental health nurse specialist] had established a good relationship with [the man]. On the day of the assessment [the mental health nurse specialist] says that [the man] agreed to participate in the assessment. [The mental health nurse specialist] is an experienced mental health professional and she discussed [the man's] case with her colleagues. [The mental health nurse specialist] had access to [the man's] records from other institutions and also took part in [the man's] ACCT reviews."

87. The mental health nurse specialist is employed directly by the prison, unlike her colleagues who are provided by Manchester Mental Health and Social Care Trust. Her post is focussed on prisoners who have mild or moderate mental health needs – a group that have a wide variety of needs. The mental health nurse specialist spoke very positively about her work and the impact it has, particularly for prisoners in the early days in prison. When asked by my investigators about clinical supervision, the mental health nurse specialist, who is managed by the deputy head of healthcare, said that she did not have such an arrangement. In her unique role in the prison, it would be beneficial for her to have the support of regular clinical supervision sessions. I do not think that the lack of clinical supervision

detracted from the care which she gave to the man and so I do not make a recommendation. However, I suggest that the Governor and Head of Healthcare should consider providing regular clinical supervision for the mental health nurse specialist.

88. The clinical reviewer highlights that, while he was at Manchester, the man had a great deal of attention from mental health and general healthcare teams. In addition, the plans to meet his needs were comprehensive. He makes no recommendations in his clinical review.

The man's risk of self-harm

89. While still in reception at Manchester, the man told staff that he planned to take his life by refusing to eat or drink. Shortly afterwards, he said that if his television was ever taken away from him, he would kill himself by hanging. During the ACCT assessment, he said that he had harmed himself as a teenager and had once attempted suicide. Throughout his time in the prison, he repeated this information to different members of staff. Staff discovered 'suicide' letters in his cell that went into great detail about his thoughts and wishes about his death and funeral.

90. Staff opened ACCT support and monitoring with admirable speed and completed all the necessary procedures well within the timescales. Many of the entries made by officers on the wing are of a high standard. The case reviews were held regularly and were well documented.

91. I have found that staff took care to support the man without putting other prisoners at risk. Therefore, although many people on ACCT plans share a cell, the man remained in a single cell. Similarly, many prisoners with problems are helped by speaking to a Listener in private. Again, because of the risk he posed to others, the man was not allowed to use the Listener service. However, he could use the cordless telephone that connects directly to the Samaritans.

92. The mental health nurse specialist took the man on to her caseload and talked very regularly with him. She slowly built up a relationship with him to the point where he agreed that she could assess his mental health. She concluded that he did not have any psychotic tendencies but did have "some depressive features". When she contacted the Edenfield Unit, she learned that their earlier assessment had concluded that he had an anti-social personality disorder with narcissistic traits.

93. A wing manager alerted staff that the man might try to manipulate them into getting his own way. This is something that all prison staff are warned to be aware of and to prevent.

94. The ACCT case managers, particularly the SO who had chaired the review on 23 October, decided to manage the man's two main issues separately. They concentrated first on his refusal to accept food and fluids until the man began to drink normally and eat most days. Then their attention turned to his refusal

to attend work or education and to engage in his sentence plan. I think that a great deal of good work was done in managing the man during the first two months in Manchester and staff are to be commended.

Supervision by the Offender Management Unit (OMU)

95. The overall responsibility for creating and managing the man's sentence plan and potential release arrangements remained with his community-based offender manager. However, the day to day liaison with the man and implementation of the sentence plan was the responsibility of an offender supervisor who was also a discipline officer. The man was assessed as a high risk of harm to the public and to specific individuals. He was designated at MAPPA level 3, Tier 4, the highest risk of offender supervised by the National Probation Service.

96. While there is evidence that the offender supervisor/discipline officer made every effort, within his training and abilities, to engage the man in the supervision and sentence planning process, the investigation has found shortcomings in the allocation of high risk cases and wider training issues. The offender supervisor/discipline officer told the investigators that he had not had risk management training but had learned "on the job" by sitting with other more experienced discipline officers. The Offender Management Unit told the investigators that risk management training is available to staff. However it is evident that not all staff in the unit have been trained.

The Governor and the head of the Offender Management Unit should ensure that all offender supervisors with responsibility for managing high risk offenders undergo the necessary training to manage and assess potential risk effectively.

97. A psychiatric assessment of the man prepared for his trial in 2004 for murdering his father, judged that he did not have any concept of the risk he posed to others. In my opinion, based upon his past history and his behaviour, the man's risk of self-harm and harm to others, would have merited joint work between the prison's offender supervisor and one of the unit's experienced seconded probation officers who would be trained to risk manage, engage and motivate challenging offenders like him. While the management by the OMU did not affect the outcome in this instance, I suggest that the Governor considers how to allocate high risk and very high risk prisoners like this man. The training needs of offender supervisors should include an understanding of the nature of risk and compliance with the Offender Management model.

Use of the IEP system

98. All sentenced prisoners are required by law to work or attend education during their imprisonment unless they are ill or of retirement age. Manchester also requires all prisoners to cooperate with their offender supervisor on the sentence plan. If they do not, they can be moved to the basic level and lose a number of privileges. The one that appeared to be most important to the man was that basic prisoners are not entitled to have a television. The man always

said that the rules did not apply to him as he had been sentenced by a Scottish court. He refused both to work and to engage with his sentence plan.

99. The mental health nurse specialist and the offender supervisor referred the man to the Managing Challenging Behaviour Strategy (MCBS) panel as a way to try to persuade him to co-operate. The panel decided not to accept him as the wing staff had not tried all other methods first. My investigators were given a copy of the minutes of the meeting at which the decision was made. The minutes indicated that wing staff were advised to consider behavioural contracts and anti-social behaviour compacts as well as the IEP system. However, the SO who had chaired the review on 23 October and the wing manager understood the message as to use IEP, and the wing officer remembers the advice was to manage the man "robustly" through the system.

100. The SO told my investigators that managing a prisoner through the anti-social behaviour contract might lead to the same action. Stage two of the contract triggers an IEP review where the prisoner may be moved onto the basic level of IEP system.

101. I think that the decisions of the MCBS panel and the advice it gives are too important to rely only on word of mouth to disseminate. When a wing manager does not attend an MCBS meeting, it would be very useful to send him or her the minutes of the meeting as soon as they are available. That way, verbal advice is confirmed in writing.

The Governor should consider implementing a system for providing wing managers with the minutes of Managing Challenging Behaviour Strategy (MCBS) meetings when a decision has been made about a prisoner on their wing.

Deciding to move the man to the basic IEP level

102. Each member of the IEP board which met on 17 December knew that the man had stated that if his television was ever removed, he would kill himself. The board was followed immediately by an ACCT review and the same staff were at both meetings. I assume therefore that neither the IEP decisions and the ACCT decisions were made in isolation. The wing manager told my investigators that he took advice from the other members but, as the PO, the decision was his. He decided to move the man to the basic level of the scheme and checked that the man understood why he did so.

103. Prison Service Order (PSO) 4000, Incentives and Earned Privileges contains a section on "In-cell television". It says that a television is a key privilege that can be forfeited for bad behaviour. Section 4.3 sets out exceptions to this general rule, one of which is:

> "All prisoners considered to be at risk from self-harm/suicide may be considered for in-cell TV irrespective of privilege level on a case-by-case basis."

104. The wing manager told my investigators that he knew of this provision and had used it in the past to allow a prisoner on basic level to keep his television. He said that he did not consider it for this man because he did not seem to be too affected by losing the television. He said:

> "I specifically asked [the man] what impact would that have on him, because 'I know you like your Star Trek, I know you like your Ray Mears'. 'Television's not my world, I can manage without it' or words to that effect was [the man's] reaction. 'It's not the be all and end all.'"

105. However, in contrast to this one statement, the man had said repeatedly, for over three months, that he would kill himself if his television was removed. When the man told staff that he would kill anyone sharing his cell, staff took the threat very seriously. However, when he said he would kill himself if he lost his television, staff did not treat that statement with the same level of gravity. The fact that he did not carry through his intention to starve himself to death may have detracted from the threat to kill himself over the issue of the television.

106. The wing manager told my investigators that he understood that the man's problems were behavioural rather than due to mental health issues. He thought that the mental health nurse specialist's input would decide on this question. The mental health nurse specialist noted more than once that although the man had stated that he would kill himself, he had no suicidal ideas. So, in spite of the man's statements and having been on an ACCT plan for three months, his television was taken away. At the ACCT review that followed, the SO increased the observations, although only to five per night.

107. Both decisions relied on the exercise of judgement. The clinical review considers whether different decisions would or could have prevented the man's death. His conclusion is "what turned out to be [the man's] fatal attempt at self-harm while foreseeable, was neither predictable [on balance] nor preventable". Although, in hindsight, the decision to remove the man's television might seem unwise, I am satisfied that the wing officer was aware of the policy and took account of the relevant factors.

Using the adjudication system

108. The wing officer dealt with two issues by means of the IEP system – the man's refusal to take part in his sentence planning work with his offender supervisor and his refusal to attend work or education. During the IEP board on 17 December, the wing officer told the man that if he continued to refuse to go to work, he would be subject to disciplinary action. The following day, an officer told the man to go to work. When he refused, the officer placed him on report for failing to obey a lawful order.

109. The Chief Inspector of Prisons inspected Manchester in July 2009. In the section on adjudications she noted, "Prisoners could experience the double jeopardy of being punished on adjudication and placed on basic for the same single incident". She therefore recommended, "Prisoners should not receive a punishment on adjudication and then be placed on basic for the same incident."

110. This appears to be what happened to the man, as both the IEP scheme and adjudication process were used regarding his refusal to attend work. I agree with the Chief Inspector's recommendation and repeat it here.

The Governor should ensure that managers do not use both the IEP scheme and adjudication process in response to the same single incident.

Summoning assistance to the emergency

110. When an officer discovered the man hanging, he called out to nearby officers for assistance. Two officers responded and the three officers prepared to enter the cell. The officer who had called out for assistance then used his radio to call for medical assistance and Oscar 1 to attend. As well as giving his location he said that the emergency was "a hanging".

111. The registered general nurse told my investigators that the official way to call for assistance is to say "Priority 1" followed by the nature of the emergency. She said that when staff heard such a call, all available staff would attend. However, she also said that staff often omitted to use the Priority 1 call and just called for Hotel 1 and Oscar 1, as this particular officer did. In the event, staff responded quickly and CPR began as soon as officers laid the man on the floor. However, the Governor may wish to remind staff to use Priority 1 to highlight a situation that requires emergency assistance from healthcare and discipline staff.

CONCLUSION

112. The man who died was a troubled young man who presented a number of challenges to those in prison and the community who had to manage his care and the risk he posed to others. He committed the most serious of offences, murder, while he was still an adolescent. He was twice recalled to prison after breaching the conditions of his licence, on the second occasion less than 24 hours after being released.

113. Shortly after arriving in Manchester, the man told an officer that he did "not fit in with society". His subsequent actions proved it an insightful comment. He threatened to kill any prisoner who he had to share a cell with and threatened to kill himself if his television was removed. He refused to engage with his offender supervisor and would not attend work or education. He refused appointments with doctors and would not be persuaded to have a psychiatric assessment.

114. From what I have learnt, he was an articulate and determined young man who made his own mind up about how he served his sentence and was not easily persuaded to change his mind. He said that he would kill himself one day, either in prison or after release. Like the clinical reviewer, I think that his death was foreseeable in that he said many times that he would kill himself. Regrettably, although he said several times that losing his television would lead him to harm himself, increased ACCT monitoring was not enough to keep him safe after he was reduced to the basic regime the day before he took his life.

RECOMMENDATIONS

1. The Governor and the head of the Offender Management Unit should ensure that all offender supervisors with responsibility for managing high risk offenders undergo the necessary training to manage and assess potential risk effectively.

   The recommendation was accepted. The National Offender Management Service (NOMS) responded as follows:

   "All Offender management unit staff receive training in offender risk management and into the offenders risk of re-offending and risk to the public.

   "OMU managers are conducting a review of staff training to establish further needs."

2. The Governor should consider implementing a system for providing wing managers with the minutes of Managing Challenging Behaviour Strategy (MCBS) meetings when a decision has been made about a prisoner on their wing.

   The recommendation was accepted. NOMS responded as follows:

   "All wing managers will be provided with a copy of the minutes of Managing Challenging Behaviour meetings."

3. The Governor should ensure that managers do not use both the IEP scheme and adjudication process in response to the same single incident.

   The recommendation was partially accepted. NOMS responded as follows:

   "The incentives and earned privilege scheme will be reviewed in line with prison service instruction 11/2011.

   The disciplinary system and the IEP scheme are two separate systems. Privilege levels are determined by patterns of behaviour and the adjudication process helps maintain order and discipline within the prison by awarding punishments for specific incidents.

   There may be occasions when behaviour results in both disciplinary proceedings for a specific act and a review of privilege level because a prisoner's behaviour falls below expected standards.

   "The loss of a particular privilege following an adjudication or at the Governor's discretion should not automatically result in the loss of IEP status."

Comments from the man's family

Following receipt of the draft report, the man's family asked why there had been no investigation into the involvement of probation in the man's death. They had major concerns about the treatment by probation. In respect of the role of the Probation Service, my report has dealt with the role of the Offender Manager in meeting the

man at Forest Bank and recalling him to prison. As the events at the Approved Premises occurred 18 months before his death, I judged that there was insufficient connection with his death to warrant further investigation. The family have other concerns and expect to raise those matters directly with the Coroner at the inquest.