



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Northallerton in December 2012**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in his cell at HMP Northallerton in December 2012. He was 29 years old. I offer my condolences to his family and friends.

A review of the man's clinical care in prison was undertaken. Staff at HMP Northallerton and HMP Hull were interviewed. Both prisons cooperated fully with this investigation. Shortly after his death, the investigation was suspended at the request of North Yorkshire police, who were conducting enquiries. I am sorry for the consequent delay in the issuing of this report.

Many sad stories cross my desk, but this report is a particularly dispiriting one of a tragic and vulnerable young man with poor mental and physical health, who was serving a sentence for offences of violence against his parents. Although he appeared to cope reasonably well in prison, and received a considerable amount of sympathetic care at both establishments, there were significant doubts about his level of understanding of the issues affecting him.

The investigation has identified some deficiencies in communication between staff at Northallerton about the man's management, but I am satisfied that it would have been very difficult to foresee his action and prevent his death. As Northallerton has now closed, no recommendations have been made.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was remanded to custody at HMP Hull on 30 April 2012, charged with actual bodily harm after assaulting his parents in a domestic dispute. He was convicted the following day and later sentenced to 18 months in prison. He had been treated in the community for schizophrenia, a long-term psychotic illness.
2. When the man arrived at Hull, a first night officer began ACCT monitoring (prison suicide and self-harm prevention procedures) because of his mental health problems and he appeared very nervous. The ACCT was closed on 2 May after he seemed more settled.
3. The man was on the caseload of the mental health in-reach team at Hull and a nurse and the visiting consultant forensic psychiatrist reviewed him monthly. His mental health appeared increasingly stable as his medication changed from olanzapine to piportil and he gave no cause for concern.
4. The man lived on a standard wing in Hull. Staff became increasingly concerned about his personal hygiene and the cleanliness of his cell. He was given extra bedding and help from other prisoners to keep his clothes and cell clean. He had clothes sent to him as prison clothes did not fit him. He smoked heavily and was seen swapping his meals for tobacco. An investigation concluded that he did so willingly and was not being bullied.
5. On 15 November, the man transferred to Northallerton, a specialist resettlement prison that is now closed. He lived on the smaller of the two wings in semi-open conditions in a shared cell. Because of difficulties he had faced at Hull, staff immediately put measures in place to help him keep himself and his cell clean and to manage his tobacco. Despite this his personal hygiene deteriorated to the point that other prisoners complained to staff about him. He was also seen stealing tobacco from other prisoners' cells. Staff became increasingly concerned that his behaviour would make him vulnerable to being assaulted by other prisoners on the wing. On 26 December, he was moved to a single cell on the other wing.
6. A few days later at 8.26pm, the man was found hanging in his cell. The emergency response was prompt and efficient but, sadly, he died.
7. We believe that communication between departments at Northallerton could have been better. Wing staff were not aware that the man was on the caseload of the mental health in-reach team and his care co-coordinator was not consulted about his move to a different wing and whether this might affect him. Nevertheless, we consider that the decision to move him was reasonable in the circumstances and that he understood that it was to be for a short time. We do not consider that prison staff could reasonably have foreseen or prevented his death.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at Northallerton informing them of the investigation and inviting anyone with information to contact her. No one came forward.
9. The investigator met a Detective Chief Inspector on 4 January 2013 for a joint meeting under the Memorandum of Understanding agreed between our office and the Association of Chief Police Officers. The DCI asked that she not conduct any interviews until the police were satisfied that no criminal charges would be brought in connection with the man's death. A further meeting with the Crown Prosecution Service took place on 10 January. The police retained primacy of the investigation until 24 July 2013 and our investigation was suspended until then. We are sorry for the consequent delay in the issue of this report.
10. The investigator visited Northallerton on 4 January and met the Head of Operations and Security. She visited the wing where the man had lived, spoke to a Senior Officer (the prison's family liaison officer) and collected copies of the man's prison record and other relevant paperwork. On 28 August 2013, she interviewed five members of staff at Northallerton.
11. North Yorkshire and Humber Commissioning Support Unit commissioned a clinical reviewer to review the man's clinical care in prison. With the agreement of North Yorkshire Police, the investigator and clinical reviewer interviewed three members of staff on 18 February 2013.
12. The investigator and one of our family liaison officers visited the man's family on 13 February 2013. The family liaison officer also spoke to the man's father by telephone when we re-opened our investigation. The family asked us why he had transferred to Northallerton just a few days before he was due for a mental health assessment. They asked what mental health care he had received in both prisons. They asked whether he had been bullied in Hull. His family also asked whether plans had been made at Northallerton to move him to a prison closer to home and why he had moved wings. These issues are addressed in this report. The family raised other issues about his time in prison which we understand were dealt with by the police investigation.
13. The investigator liaised with HM Coroner for North Yorkshire (East), who provided a copy of the post-mortem report. An inquest into the man's death concluded on 1 November 2013. The jury returned a narrative verdict. The coroner has been sent a copy of this report.

HMP NORTHALLERTON

14. HMP Northallerton closed in November 2013. It was a community prison and held an average of 220 adults and young offenders. It was part of a cluster of prisons with HMPs Hull, Everthorpe and Wolds. HMP Hull is a category B local prison taking remand and sentenced prisoners from the local courts. Those serving short sentences usually remain there but others are allocated to one of the other prisons in the cluster. Northallerton specialised as a resettlement prison. There were two wings, A and C. C wing had 45 cells, some of which were shared. The prisoners were all category D (the lowest security category, suitable for open conditions) and lived in semi-open conditions.
15. Harrogate and District NHS Foundation Trust and Leeds and York Partnership Trust provided healthcare services at the prison with nurses on duty during the day. A GP was available six days a week with an out of hours service provided by a local GP practice. Two mental health nurses provided primary care. Mental health in-reach (for prisoners with severe and enduring mental health issues) was provided by one community psychiatric nurse (CPN) with a visiting consultant forensic psychiatrist as required.

Her Majesty's Inspectorate of Prisons

16. Her Majesty's Inspectorate of Prisons last inspected Northallerton in January 2011. Inspectors described the prison as impressively safe and respectful with plenty of activity and a sound focus on resettlement. Staff/prisoner relationships were very positive and were supported by an impressive personal officer scheme. Prisoners were very positive about the staff and inspectors reported their friendly and constructive manner.
17. Inspectors noted anti-bullying and violence reduction strategies were well established and prisoners said staff took these issues seriously. Inspectors found appropriate investigation into allegations of bullying. Suicide and self-harm monitoring was of a high standard and prisoners on suicide and self-harm monitoring procedures (ACCT) were well supported.
18. Prisoner satisfaction with healthcare was high and officers had good access to mental health awareness training.

The Independent Monitoring Board (IMB)

19. Every prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The 2013 Northallerton IMB report commented that staff-prisoner relationships were extremely good and praised staff for their inter-personal skills. The IMB was also impressed with the care of vulnerable prisoners at Northallerton and noted that the man's death had caused deep distress among staff and prisoners.

Previous deaths at Northallerton

20. The man's death was the third of three deaths at Northallerton between April 2004, when the Ombudsman began investigating fatal incidents and the prison's closure in November 2013. One of the previous two was a death by drugs overdose within 48 hours of release into the community. The other was an unexpected death from natural causes. There are no similar issues with his death.

Care Programme Approach (CPA)

21. The Care Programme Approach is a system for delivering community mental health services to people with mental illness. Health and social services assess need, provide a written care plan and appoint a care co-ordinator to oversee the person's care. The plan should be regularly reviewed. When person goes to prison the CPA transfers with them and their care co-ordinator in prison liaises with their care co-ordinator in the community.

Multi Agency Public Protection Arrangements (MAPPA)

22. MAPPA is a set of statutory arrangements for supervising prisoners convicted of violent or sexual offences. MAPPA provides a structure by which the various agencies a prisoner comes into contact with (the police, probation service and prison service) can share information and monitor risk factors after the person is released from prison.
23. Each prisoner supervised under MAPPA has an Offender Manager – a probation officer based in their home probation service who is the point of contact for them and their family. Prisoners also have an Offender Supervisor, a member of staff based in the prison's Offender Management Unit (OMU).
24. Before release the Offender Manager collates information from the prison and police and the local probation service decides what level of management the person will need in the community. MAPPA level one is management within normal management procedures. MAPPA level two requires a meeting between agencies to agree a risk management plan. MAPPA level three is for people who require extra resources because they pose a serious risk of harm to themselves or to others.

ACCT (Assessment Care in Custody and Teamwork)

25. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. An ACCT plan can be opened 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.

KEY EVENTS

26. The man was born in Hull. When he was four years old he suffered a serious head injury in a road traffic accident. He had four convictions (in 2001, 2002, 2004 and 2012) for assault and criminal damage as a result of domestic disputes, usually while under the influence of drugs or alcohol. In 2005, he was diagnosed with a chronic long-term psychotic illness (schizophrenia). He had daily auditory hallucinations which resulted in verbally and physically aggressive behaviour. He was prescribed olanzapine (an anti psychotic) that caused him to gain a significant amount of weight. His medication became ineffective when mixed with alcohol and this increased his risk of violence. In the community, he was managed under the Care Programme Approach (CPA) with a community psychiatric nurse (CPN) as his care co-ordinator.
27. On 28 April 2012, the man went to a pub with his mother and father. He drank several pints of cider and became aggressive when told he could not have another drink. When the family returned home, he seriously assaulted his mother and father. He was arrested and remanded to custody in HMP Hull on 30 April.

HMP Hull

28. During his first night interview, the man said he had mental health issues for which he received medication. He said he felt fine but had self-harmed several years earlier by making scratches and cuts to his hands and fingers. The first night officer opened an ACCT because he had mental health problems and appeared nervous. The reception nurse referred him for assessment by the mental health in-reach team as he was managed under the Care Programme Approach (CPA) in the community.
29. The next day on 1 May, the man was convicted of actual bodily harm and battery. The Humberside diversion from court team (an NHS team based in court who help people with mental health problems who are in contact with the criminal justice system) telephoned a nurse from the prison mental health in-reach team to tell her he was returning to Hull. They told her he was managed under the CPA and was prescribed a depot injection (an injection into the muscle of the buttock at regular intervals which forms a reservoir of medicine which is slowly released into the bloodstream) and olanzapine. She asked the court team to contact his care co-ordinator and fax her all the relevant information about his prescription. (He was in the process of changing prescription from olanzapine to piportil (another anti psychotic) and was on a reducing dose of olanzapine and receiving increasing doses of piportil.)
30. The man's ACCT was closed on 2 May because he appeared to be more settled. A post-closure review was held the same day. A nurse assessed him on 3 May. She said he found it difficult to stay awake during the assessment and complained that he was having difficulty sleeping at night. He had a cell on the fourth landing and found this difficult because his weight meant that he became breathless walking up to it. He said he heard voices of a male and

female who shouted at him all the time, calling him names and urging him to hurt himself. The voices also told him to hurt others but he ignored them. He said he had no history of suicidal thoughts but had self-harmed in the past to release stress. The nurse concluded that he should be taken on as a patient of the mental health in-reach team. Later the same day, she gave him his depot injection and asked the wing staff to find him a cell on a lower landing.

31. The nurse became the man's care co-ordinator at Hull. She wrote a care plan for him that included monthly reviews when he had his depot injections and input from the visiting consultant forensic psychiatrist. During his time in Hull, the nurse also liaised with his current community care coordinator (a CPN) and his offender manager from Humberside Probation Trust. The nurse spoke regularly to wing staff about him, had telephone contact with his parents and input into the decisions about how to manage him.
32. On 21 May, the man's offender manager completed a pre-sentence report. She had interviewed him and spoken to the nurse and the man's previous community psychiatric nurse and CPA care co-ordinator. The offender manager said he had needed help completing a self-assessment questionnaire and gave the impression of having "a lower level of comprehension requiring me to reframe questions to aid his understanding". She reported that the community psychiatric nurse had told her that the man's mental health had yet to be successfully managed and that during unstable periods he could respond to the voices in his head, lose self-control and become aggressive. He also confirmed that the man had a memory problem, possibly due to his brain injury.
33. The offender manager concluded that the man would not have particular difficulty coping in prison. She said current information indicated that he presented a high risk of serious harm to his family, especially when using alcohol. She suggested the court consider deferring sentence for a specialist mental health assessment to be obtained. She said the psychiatric nurse agreed with her that consideration should also be given to the suitability for a Hospital Order under the Mental Health Act (under which the court can decide that someone should be in hospital rather than prison) with a view to stabilising his medication in a controlled environment away from alcohol. She said such an assessment would verify the level of his brain damage and help decide on an appropriate sentence.
34. The psychiatrist instructed by the court to complete a specialist mental health assessment did not recommend a Hospital Order and on 10 August, the man was sentenced to 18 months for ABH and four months for battery, to be served concurrently. He would be eligible to apply for release on home detention curfew (HDC – when a prisoner wears an electronic tag and agrees to stay at an agreed address during certain hours) on 17 September. His conditional release date was 29 January 2013. He was assessed as security category D, the lowest security category, which meant that he was eligible for transfer to an open prison.

35. The man lived on a standard wing at Hull. He attended education classes for a short while but kept asking to be sent back to the wing as he felt unwell. He subsequently said he did not want to attend. An attempt was made to interest him in education on the wing but again he said he did not want to take part. He also declined to attend the gym. His prison record shows he spent most of his time on the wing in bed in his cell.
36. It is apparent from his prison record that wing staff believed the man had learning difficulties. Entries show an ongoing concern about his personal hygiene and that he would be vulnerable to bullying as a result. He was allowed to shower on his own and a laundry orderly washed his clothes, towels and bedding daily. Another prisoner became his cleaning 'buddy' and helped him clean his cell. His family were allowed to send him clothes because prison sizes were too small.
37. At the end of June, staff became concerned that the man was getting into debt by borrowing tobacco from other prisoners. He was also seen swapping his meals for tobacco. A move to a different wing did not improve matters and, in early August, staff opened a support plan used for prisoners regarded as potential victims of bullying. The subsequent investigation concluded that he was voluntarily exchanging his food with other prisoners for cigarettes. The support plan was then closed.
38. On 17 September, the man applied for early release on home detention curfew but was refused on the grounds that he was likely to breach the conditions of any order imposed on him. He was regarded as a high risk of serious harm to his parents and his release address was his parents' home.
39. The man's hygiene and frequent approaches to other prisoners for tobacco continued to cause concern. By late September, other prisoners refused to share a cell with him. On 30 September, after a number of warnings about not showering or cleaning his cell and smoking in non-smoking areas, he was put on basic regime under the incentives and earned privileges scheme. Three weeks later he was returned to standard regime after complying with his daily plan to shower, clean his cell and smoke only in permitted areas.
40. On 28 September, a nurse completed a relapse and risk management plan to list signs and symptoms that would let the man and others know if his mental health was deteriorating so that a relapse would be prevented. She explained to the investigator that this is a routine plan completed for all prisoners under the care of the mental health in-reach team. He identified hearing voices, having strange or suicidal thoughts, deteriorating hygiene and finding it difficult to sleep as behaviour suggesting a possible relapse. He listed positive coping strategies as relaxation, keeping busy, talking to staff and other prisoners and taking his medication. Negative coping strategies were using illicit substances, excessive alcohol, isolating himself and not taking his medication. She said there was no sign that he was about to suffer a relapse in his mental health and that he never expressed any suicidal thoughts to her.

41. On 2 October, the man attended a sentence planning board with his offender supervisor, his offender manager and a nurse. They discussed his release from prison at the end of January and explained the licence process to him. The nurse said she was not sure he fully understood this although he said he did. After discussion with the psychiatrist, the nurse arranged a learning disabilities assessment by the prison's chartered clinical psychologist. The assessment was scheduled for late November.
42. On 15 November, the man transferred to HMP Northallerton as a standard progressive move from Hull. He was passed medically fit for transfer by a nurse in reception. The nurse said she remembered getting a telephone call that afternoon to say that he was on his way to Northallerton. She telephoned the mental health in-reach team nurse at Northallerton the same afternoon to give her a verbal handover and faxed copies of his care plan and risk and relapse management plan. She also informed the offender manager.

HMP Northallerton

43. During his first reception health screen at Northallerton, the man said he was concerned about being overweight and that he suffered from indigestion. He was referred to the GP. He told the nurse what medication he was on and she referred him to the mental health team. He said he had no thoughts of suicide or self-harm. At his first night risk assessment and induction interview, he said that he had never deliberately harmed himself and did not feel like doing so. He was allocated to C wing.
44. On 16 November, the mental health in-reach nurse at Northallerton went to see the man on C wing. She explained to him that he would receive his depot injection from her and that he would be referred back to his community mental health team when he was released.
45. On 17 November, a Senior Officer (SO) and the A and C wing manager visited the man. The SO told the investigator that a member of staff had suggested she spoke to him because they were concerned that he might be vulnerable to bullying. She had read his PNOMIS entries (PNOMIS is the electronic prisoner record) and noted that he had briefly been on an ACCT at Hull and also had several negative entries about his hygiene and use of tobacco. She said she wanted to work with him to manage his behaviour rather than disciplining him for not conforming. She cleaned his cell with him and his cellmate to show him how to clean, to satisfy herself that he was able to do it and to show him the standard she expected. The SO also arranged for the laundry orderly to wash his clothes and bedding daily instead of weekly as was usual. She got him some extra clothes and ensured he had tobacco. She said he appeared to have a good relationship with his cell mate and told her that he was pleased to be away from Hull.
46. Officers told the investigator that the man responded when he was spoken to and appeared to understand them but they were not sure how much information he retained. He did not initiate conversation and generally replied 'yes' to every question. They said they thought he had learning difficulties.

As at Hull, his personal hygiene and demands for tobacco began to cause problems with other prisoners. He had to be reminded and cajoled into following his daily plan to have a shower, put on clean clothes and to clean his cell. It became apparent that he was going to the showers but not washing himself. As at Hull, he spent most of his time in his cell watching TV.

47. Officers said that initially some of the older prisoners on C wing took the man under their wing and helped him out when he ran out of tobacco so that he did not get into debt. The SO created a job stamping envelopes for him so that he was able to earn money to buy tobacco and had a reason to get up and get out of his cell but after a week or so, he said he did not want to work. Officers then took him more frequently to the exercise yard to encourage him out of his cell. He spent the time collecting cigarette butts from the ground. Staff split his tobacco allowance into portions to try to help him make it last so that he did not borrow too much from other prisoners but he smoked it all very quickly. They discovered that his cellmate had been ordering tobacco for him even though he did not smoke and the man's mother had been paying for it.
48. A multi-agency public protection meeting (MAPPA) took place on 21 November in Hull, where it was decided that he should not be released to his parents' home because of concern for their safety. It was agreed that a place should be found for the man at approved premises (a probation hostel) in Hull.
49. By early December, the man's behaviour was reported to be causing bad feeling amongst the other prisoners on C wing. They complained about the smell from his cell and that he was constantly asking for tobacco and taking it from their cells. On 2 December, an officer wrote in his record that she intended to speak to the mental health team about him. She told the investigator that she felt that wing staff were doing all they could to try to encourage him to keep himself and his cell clean and to manage his tobacco, but she thought that both he and the officers needed more support. She remembered speaking to the nurse on duty but there is no record that anyone visited him as a result.
50. On 7 December, an offender supervisor at Northallerton, the offender manager, the community care co-ordinator, the manager of Queen's Road Approved Premises in Hull, a nurse, an officer from the man's wing and the man attended a pre-release sentence planning meeting to discuss arrangements for his release in January 2013. In a statement to North Yorkshire Police, the offender supervisor said that the man was told that he would not be going home on release but would be going to Queen's Road. He described him as "quite shook up" by this but said he was happy when he left the meeting. The offender manager said he was visibly agitated during the discussion about his release arrangements and his hand and leg were shaking. She said they tried to explain the multi-agency public protection arrangements and how they linked to his release plans but he just kept saying that his Dad had sorted everything and he would be going home.
51. The nurse said the man seemed unable to grasp the importance of going to a hostel on release and said he would refuse to go there. The offender

manager tried to explain to him that he would be recalled to prison if he did not. He said his family had told him he did not need to go to the hostel and could go home. The nurse said he had not appeared upset but had simply stated was not going to the hostel. The meeting decided to try to re-arrange the learning disabilities assessment with the psychologist. The nurse also agreed to advise the prison that he should be moved to a prison closer to his parents' home to make it easier for them to visit and support him. No action appears to have been taken about this before his death and there is no other reference to it.

52. On 10 December, the offender manager spoke to the psychologist about the man's learning difficulties assessment. He told her that he did not think that the prison environment was suitable for such an assessment. He suggested an IQ test and she told the nurse that this would now take place in the community after his release. The next day, she visited his parents, who said that they wanted him to return home when he was released. She told them their views would be put forward to the next MAPPA meeting on 19 December.
53. The MAPPA meeting took place as scheduled in Hull. The offender manager, the community care co-ordinator and representatives from the local police, probation, social services and mental health services attended. The meeting discussed the man's release arrangements in depth. The probation service was concerned about the effect on him of living in approved premises and his potential risk to staff and other residents. His family were concerned that he would have access to illegal drugs in the hostel. The police and children's services refused to support a decision that he should return home to live with his parents. As a result, the meeting decided that he should be assessed for a Guardianship Order (which would give the authorities some legal powers over where he lived and the power to remove him if there was evidence of increased risk). The meeting also decided that he should have a psychological/IQ assessment as a matter of priority. His release address would not be finalised until these assessments had taken place and a robust risk management plan agreed. The panel agreed that his case should be discussed as soon as possible at a MAPPA level three meeting.
54. On 25 December, an officer wrote in the man's record that his hygiene was very poor. He often refused to get out of bed to have a shower and his clothes were filthy. He was given clean clothes but refused to change into them. She said she had spoken to healthcare staff and asked if the mental health team would come and see him. She was told a member of general nursing staff would see him the next morning.
55. A nurse wrote in the man's medical record that staff on C wing were concerned about his hygiene and that he had been stealing. She listed the concerns and wrote that a nurse would review him the next morning.

Transfer to A wing on 26 December

56. A SO told the investigator that, by 26 December, more and more prisoners were asking her to do something about the man's personal hygiene or move him to A wing. The laundry orderlies were refusing to wash his clothes because of the condition they were in. Officers told her that they had exhausted every avenue in encouraging him to wash and clean his cell. The other prisoners were becoming intolerant of him stealing tobacco from their cells. She said she noticed that his cellmate's condition had also deteriorated. He had previously been very clean and tidy but he now looked tired, unkempt and smelled filthy as a result of living with him. She said she did not think it was fair on the cellmate for him to continue living with him.
57. The SO decided to speak to the man in his cell to see if she could persuade him to change his behaviour. She said that he was unusually aggressive to her and told her to fuck off. She asked him to come to the wing office to talk to her. She told him that she had no option but to move him to A wing (as there were no available single cells on C wing at the time). He initially refused to move and staff walked him to the segregation unit. No force was used. The SO spoke to him again there and he appeared more his usual self. She explained that there were no single cells on C wing. He agreed that his behaviour needed to change and asked for another chance. She said the situation had gone too far for that and he then agreed to move to A wing.
58. The SO said she moved the man to the nearest cell to the A wing office. As soon as he went over there she returned to C wing and she and his cellmate packed his belongings so he would have some familiar things in his new cell. She said he got straight into bed in his new cell and asked for his ID card so that he could order canteen (items from the prison shop). He told her he would unpack his things later.
59. That afternoon, the SO held a case conference with the man, a nurse, his personal officer, an A wing officer and a wing representative (an A wing prisoner). She said she explained to him again the reasons why he had been moved. She said she impressed upon him the need for him to work with staff to help avoid him becoming vulnerable due to his hygiene and other habits. She told him that he would be staying on A wing for a week and if he complied with what was asked of him he could move back to C wing. She said he was distracted and did not appear to be listening or have an understanding of what he was agreeing to. His concentration span appeared limited and he frequently yawned and scratched himself. She made sure he knew how to call for wing staff and that he knew how to access healthcare staff if he needed them. She told him she had arranged for him to shower and use the exercise yard separately from the other prisoners.
60. The SO said she told the man that she was not putting him on basic regime but this was individual plan that meant he could still have a TV and access to his full entitlement of canteen. His main concern was his access to tobacco, so she reassured him that this would not change. He would not be allowed association periods with other prisoners until he could prove that he could be

trusted to walk to exercise and meals without asking other prisoners for tobacco or going into other cells uninvited. A nurse spoke to him about the importance of hygiene. She did not raise any concerns about his move to A wing.

December 2012

61. One of the primary care mental health nurses returned to work from leave. She noticed that the man had moved to A wing and rang the SO to ask if they could have a chat about him when they saw each other at another prisoner's ACCT review that afternoon. The nurse told the investigator that she knew the other mental health nurse was on leave and wanted to make sure that the SO had put a plan in place for managing him on A wing. She knew him from giving him his depot injections. She said she had no particular concerns about his move, but A wing was a bigger wing and had a younger population who might not be so tolerant of him. In the event, the nurse and the SO did not discuss him because the SO had to go home sick at lunchtime.
62. At 4.00pm an officer collected the man from his cell and took him to the exercise yard. No other prisoners were out. He asked him for a light for his cigarette and then spent ten minutes walking around the yard looking at the ground. The officer said he presumed he was looking for cigarette butts because he had done this before. At about 4.45pm, the officer gave him his breakfast pack for the next morning. The officer said he thanked him and appeared to be his usual self.
63. At 5.00pm, the man pressed his cell bell and asked an officer for a light. The officer borrowed a lighter from a trusted prisoner, who was still unlocked. A little while later, the prisoner told the officer that there was a funny smell coming from the man's cell. The man told the officer that he had been putting tea in his cigarette because he had run out of tobacco. The officer told him that he would be getting his canteen the next morning and that he should stop smoking the tea in case it made him sick. He promised he would not and then got into bed. The officer said there was nothing unusual about his behaviour.
64. At about 7.30pm during his evening roll check, an officer said he looked through the man's observation flap and saw him lying on the bottom bunk watching TV. At about 7.45pm, a prisoner in the cell next door heard a bang or a thud in his cell. He later told staff he had considered pressing his cell bell to tell them but as it was quiet after that he did not.
65. An Operational Support Grade (OSG) came on duty as night patrol officer on A wing at 8.00pm. She began checking all the prisoners in their cells for evening roll count. This involved going to each cell, opening the observation flap in the door and making sure that the correct prisoner was in the cell. She began her count on the third landing and worked her way down to the first (ground floor). When she got to the man's cell, she opened the observation flap and saw that he was hanging from the window bars at the back of the cell. She immediately called out for help from the night orderly officer (NOO) and the Assist NOO, who she knew were in the A wing office, next door but

one to the cell. (As a night patrol officer, she did not carry keys, but had a cell key in a sealed pouch, for use in an emergency.)

66. Both officers responded immediately. The Assist NOO looked through the observation flap. He saw the man at the back of the cell, sitting on a chair with a green bed sheet tied around his neck and attached to the open window bars. He unlocked the cell and went in followed by the NOO. Both men then lifted him sufficiently for the Assist NOO to be able to cut the sheet from around his neck using his cut down tool (known as a fish knife). They removed the sheet, laid him on the cell floor and started cardio pulmonary resuscitation (CPR). The OSG radioed a code blue emergency and asked for an ambulance to be called. The Assist NOO told the police that he was confident he was already dead but he and the NOO continued CPR. The OSG joined them in response to the code blue and he took over rescue breaths from the NOO. The NOO collected the defibrillator from the centre and attached it to the man. The defibrillator advised no shock and to carry on with CPR. Both officers continued CPR until paramedics arrived.
67. The OSG went to the gate to meet the ambulance and escorted the paramedics to the man's cell. The paramedics gave him oxygen and told the staff to continue CPR. Shortly before 9.00pm the paramedics told the staff to stop CPR and pronounced him dead.
68. CCTV footage shows that the OSG checked the man's cell at 8.26pm. She and both officers went into the cell within seconds and the code blue was called at 8.28pm. The control room log showed that the ambulance was called at 8.29pm and arrived at the gate at 8.33pm. CCTV shows that the paramedics arrived at the cell less than a minute later.

Support for staff and prisoners

69. All prisoners on open ACCT forms were reviewed. A hot debrief for all staff in attendance was held that evening. A critical incident debrief took place on 9 January facilitated by the Ministry of Justice workplace support group. The anonymous feedback forms completed by seven of the nine staff who attended this were generally positive about the support they had been offered. However, when interviewed some staff told the investigator that they were unhappy with the support they had received after the death. This was fed back to senior management.

Family liaison

70. The prison asked the local police in Hull to break the news of the man's death to his parents that night. (We would normally expect this to be done by a member of the prison staff but as Northallerton has now closed this issue is not pursued.) At 5.15pm the next day, the Duty Governor and the prison chaplain visited the man's parents. The police family liaison officer was also at the meeting.

71. The Head of Security and two officers attended the funeral. The prison held a memorial service for the man on 27 January 2013 and paid for his brother and best friend to attend. A Senior Officer remained in touch with his family.

Post-mortem report

72. A post-mortem examination took place on 29 December 2012. The man was found to have swallowed a plastic knife but this did not cause or contribute to his death. There was no evidence to suggest that this had caused choking. The cause of death was hanging.

ISSUES

The man's transfer from Hull to Northallerton

73. The man was a category D prisoner and therefore eligible to serve his sentence in an open prison. Hull is a category B local prison. Unless there is a special reason why they should remain in Hull, prisoners are routinely transferred to one of the other prisons in Humberside/North Yorkshire cluster. Northallerton was a specialist resettlement prison and C wing offered semi-open conditions to prisoners preparing for release into the community. He was moved there as part of a natural progression through the prison system.
74. If a prisoner needs to remain in a particular prison for a medical reason, healthcare staff can place them on medical hold. A mental health nurse and a psychiatrist told the investigator that there was no medical reason for the man to remain at Hull. Although they were not consulted about his transfer, they were not concerned that he had moved to Northallerton. The psychiatrist felt that Northallerton, a smaller lower security category prison, would be more suitable for him. He said his was a very straightforward case to manage and Northallerton had a mental health in-reach service. The nurse would have preferred to have known a little in advance in order to liaise with another mental health nurse before the move.
75. The man's family asked why he was transferred from Hull when he had a learning disabilities assessment with the prison psychologist booked for late November. It is our understanding that the learning disabilities assessment was primarily for use in determining how he was to be managed in the community. When the psychologist was approached to reschedule the appointment in Northallerton, he said that he did not think it was appropriate that the assessment should take place in prison and suggested it should be done after his release. There was clearly some concern among a number of the professionals involved in his care that he had undiagnosed learning disabilities. Conversely, the psychiatrist thought that he had some cognitive deficits caused by chronic schizophrenia, rather than learning difficulties. We understand the family's frustration that he was moved before this assessment took place but the results of any such assessment would not have had a bearing on where he served his sentence and was not sufficient reason for him to have remained at Hull.

Management in prison and risk of suicide/self-harm

76. The mental health nurse told the investigator that the man appeared to cope with his symptoms of schizophrenia at Hull. She was not concerned about his ability to cope in prison and did not think he needed to be in a hospital. He became increasingly stable as his medication was changed from olanzapine to piportil and she never had any concerns that he was having suicidal thoughts or was at risk of self-harm. The psychiatrist told the investigator that he was a typical patient with schizophrenia. He had a number of associated negative symptoms including apathy. He appeared to cope quite well in prison and was calm, quite happy and not overtly psychotic at his

appointments. The psychiatrist did not think that he needed to be in a hospital nor had he been concerned that he was at risk of suicide or self-harm.

77. The man had a history of minor cutting to his hands to relieve stress with the last reported occasion about three or four years previously. An ACCT was opened in reception at Hull as a precautionary measure - partly because of his presentation, his history of mental illness and what he said at interview. Staff agreed on 2 May 2012 that his ACCT could be closed, as he appeared to have settled well. We are surprised to note that a post-closure review was held on the same day. As the purpose of the review is to ensure that the improvement in the prisoner's behaviour and demeanour has been maintained, it is difficult to see how this could be properly assessed on the same day the ACCT has been closed. The fact that the ACCT was closed so quickly appears to indicate that those involved did not consider it was necessary.
78. Although the post-closure review appears to have been premature, we note that the man was reviewed by a psychiatrist a month after the ACCT closure, and was given other means of support. No concerns were raised about his risk of suicide and self-harm at the time and we are satisfied that closing the ACCT was appropriate.
79. A SO told the investigator that the man never gave her any indication that he was unable to cope in prison or that he was at risk of suicide or self-harm. She said that he was a very private person and never talked about himself at all. She only knew that he heard voices because his cellmate told her. His cellmate did not raise any concerns about him with staff. Despite their good relationship the SO did not believe he would have told her if he was upset or worried about something. She said she knew he was vulnerable to being picked on by other prisoners and had tried to protect him from that. This investigation and the police investigation found no evidence that he was a victim of bullying at Northallerton.
80. A mental health nurse saw the man almost once a week, usually in his cell on C wing. She told the investigator that he appeared to be coping well and was sharing a cell with someone he liked. His mental health appeared stable with his medication and she had no concerns that he was deteriorating. When she saw him he seemed placid and told her that he was going home soon. She was aware from wing officers that he lacked motivation and required a lot of encouragement to do things. She knew that he needed encouragement to shower but when she visited him in his cell she had not noticed any odour and he had not appeared in a state of dishevelment. She only found out about the level of concern about his hygiene after his death.
81. The nurse said his self-neglect appeared to be a historical problem rather than a result of poor mental health (the man reportedly told staff and his cell mate that at home he mostly stayed in bed and had his meals brought to him and his clothes and bedding washed by his mother). She recorded that he was not displaying symptoms of mental illness and was taking his medication.

He had no history of attempted suicide and no reported current suicidal thoughts.

82. Although wing staff have told the investigator that they asked mental health staff for support in managing the man, we have not found any evidence they received it. The nurse has told us that she was not aware of how bad either his personal hygiene or his tobacco debt was. She was not informed that he was to be moved wings and told us that she thought it might have been better to have moved him after the Christmas period, and for her to have spoken to him before he moved. However, she was more concerned that no one had discussed the move with her rather than with the move itself.
83. The SO was not aware that the man's care coordinator was a particular nurse and had expected the healthcare team to send the person with the most knowledge of him to the multi-disciplinary meeting on 26 December. The general nurse who attended is on long term sick leave and was unavailable for interview. The SO was not aware of the meeting of 7 December, at which the man had been told that he would have to live in an approved premises when he left prison, and told us that she thought that, in hindsight, this might have been a cause of his deterioration.
84. We believe that communication between departments should have been better and it is clear that those making decisions about the man's location were not always in possession of the full facts about his medical or personal issues. However, we believe that the decision to move him to a different wing was reasonable even without all the information being available. The SO noted that his behaviour was causing problems on his existing wing, and that a fresh start would be in the interests of him, his cell mate and others on the wing. We believe that she made extensive efforts to ensure that he understood the reasons for the move and what he needed to do to move back to C wing.