Investigation into the circumstances surrounding the death of a man in January 2011 whilst in the custody of HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

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This is the report of an investigation into the death of a man who died in hospital some three days after attempting to take his own life in his cell. He was 28 years old.

One of this office's family liaison officers contacted the man's family to explain our involvement and to offer the family the opportunity to contribute to the investigation. We add our condolences to those already expressed by the family liaison officer, and apologise for the delay in issuing the report.

The investigation was undertaken by a senior investigator. We would like to thank the Governor of HMP Manchester and his staff for their co-operation throughout the course of the investigation. Manchester Primary Care Trust (PCT) commissioned a clinical reviewer to undertake a review of the man's clinical care and we greatly appreciate her assistance.

The man was serving an eight month prison sentence. Early in December, his long-term relationship with his partner ended. Throughout the month he was unable to contact her or their children, and this caused him a good deal of distress. He was placed on special measures to support prisoners thought to be at risk of harming themselves.

During the lunch period on 28 December 2010, the man went into the toilet area of the cell he shared with his friend and co-defendant, and using a ligature made from bedclothes he attempted to take his own life. His cellmate found him and alerted staff, and with medical help they were able to keep him alive while he was transferred to hospital. However, his condition deteriorated and after consultation with his family, doctors switched off his life support machine. He died in the early afternoon of a day in January 2011.

Broadly, we believe that the man received a reasonable level of care whilst in the custody of HMP Manchester. The clinical reviewer believes that he received care comparable to that which he could have expected in the community. The report makes nine recommendations. The clinical review contains several recommendations, not all of which are contained in this report and these are drawn to the attention of the Head of Healthcare. The National Offender Management Service have accepted all the recommendations.

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 **July 2012**

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SUMMARY

1. The man was 28 years old and was sent to prison for the first time in November 2010. He came into prison during a turbulent period in his private life, dealing with some complex personal relationships. This included the break-up of his relationship with his long-term partner, with whom he had two children. Earlier in the year, in light of some of these problems, he had cut himself and taken an overdose of prescription drugs. Further to this, he had been treated for depression.

2. On reception into HMP Manchester, the man was given a standard health assessment. The papers which accompanied him from court noted his previous attempt to harm himself. However on his arrival at Manchester he was not considered to present a risk to himself at that time, nor in need of a referral to the mental health team.

3. In addition to the offences for which he had been convicted, the man was also on bail for other offences. A condition of this bail was that he should not contact his former partner. This, however, was not noted by the prison and he telephoned her on a number of occasions. These calls were often tempestuous, with the man threatening to harm himself and his former partner not attempting to dissuade him and telling him that he should not be contacting her.

4. A probation worker in the prison informed the safer custody office on 25 November of the man's previous attempts at harming himself. As a result, an officer went and spoke to him to assess whether he was at risk of harming himself again. He was judged not to be so.

5. On 1 December the man moved wings within the prison. He telephoned his former partner to inform her. During the conversation she told him that she had met someone else and that their relationship was definitely over. He was visibly upset by this, and staff placed him on special support measures for prisoners thought to be at risk of harming themselves.

6. The man continued to telephone his former partner, but was having increasing difficulty in speaking to her or their children. He remained on special support measures through the Christmas period, when he was still unable to speak to or see his children.

7. On Boxing Day, the man caused cuts to his arm. He told his cellmate, who helped him to clean the cuts, but asked him not to inform staff. His cellmate reluctantly did as he was asked.

8. During the morning of 28 December, the man did not come out of his cell. While prisoners were locked into their cells during lunchtime, he went into the cell toilet. After he had not emerged for some time, his cellmate went into the toilet and found him hanging from a bedsheet. He raised the alarm, and staff provided first aid. An ambulance was called,

and he was taken to hospital. He remained in hospital for three days until, with his family's agreement life support was withdrawn, and he passed away on a day in January.

9. We make nine recommendations. These cover recording information at reception, mental health referrals, requesting medical records, the passing of information, systems for noting bail conditions, attendance at ACCT reviews, emergency radio codes, resuscitation mouth shields, and next of kin data.

THE INVESTIGATION PROCESS

10. The Ombudsman's investigator formally opened the investigation at HMP Manchester on 7 January. The prison provided him with the man's prison record, including his medical file. He met with the Violence Reduction Co-ordinator and the Head of Safety and Decency, and spoke to staff who knew the man, including a B wing Senior Officer and a Prison Officers' Association representative. He also had an informal conversation with the man's cell mate.

11. The prison provided copies of the transcripts of telephone calls the man made in prison. Unfortunately, a problem with the technical equipment meant that CCTV footage of the wing was not available for the investigator to view. The Ombudsman's office has previously recommended to Manchester that the security department should keep master copies of CCTV footage, and it is disappointing that this has once again not been available.

12. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact my investigator. A letter from a former prisoner at Manchester was received. The prisoner did not have any personal information about the man, but made some comments on the operation of self-harm monitoring procedures in Manchester.

13. The investigator formally interviewed 10 members of staff and one prisoner. The interviews were recorded and then transcribed. Interviewees were invited to sign and return copies of their transcripts, confirming their accuracy.

14. Greater Manchester Police conducted an investigation into the circumstances surrounding the man's death. The investigator spoke to and corresponded with the officers who were involved in the investigation. There are no police actions pending as a result of the man's death.

15. Manchester Primary Care Trust (PCT) conducted a clinical review of the man's care and treatment while in custody at Manchester. This was undertaken by a clinical reviewer. The investigator met with the clinical reviewer, and discussed the report with her throughout the investigation.

16. The investigator provided feedback to Manchester during the investigation, highlighting preliminary findings and any issues that had become apparent. This included written feedback to the Governor, and verbal feedback to the Head of Safety and Decency.

17. The investigator wrote to HM Coroner for City of Manchester District to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Throughout the course of the investigation, the investigator remained in contact with the Coroner's

office. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

18. One of the Ombudsman's Family Liaison Officers contacted the man's family to explain the investigation process and offer the opportunity to ask any questions or raise any issues. He also wrote to the man's former partner, but received no response. The man's family raised the following issues:

- If the man was on suicide watch and his friend was in the cell with him, how he was able to still take his own life?

- What action did the prison take as a result of the phone calls made by the man's sisters informing them that he had expressed suicidal intent and had harmed himself?

- Why did the man have removable bed linen and access to other items in his cell that would enable him to harm himself?

- How was the man able to contact his ex-partner and send her visiting orders when part of his bail conditions was that he was not allowed to contact her?

- On the day the man hanged himself he was apparently burning a number of letters in his cell. Were staff aware of this?

19. The man's family responded to the draft report, clarifying some personal information and providing more detail on the telephone call his sister made to the prison on 17 December. We hope that this report answers the family's questions and gives them an understanding of the events surrounding the death of their relative.

20. The publication of this report has been delayed whilst we made attempts to contact the man's former partner. These attempts were, unfortunately, unsuccessful but nevertheless necessitated a period when we were unable to progress the report.

HMP MANCHESTER

21. HMP Manchester is a large local prison which accepts adult male prisoners remanded into custody by courts in the Greater Manchester area. It forms part of the Prison Service's High Security Estate. It consists of two Victorian blocks, and has a mix of single and double cells. Healthcare at the time of the man's death was provided by Manchester Primary Care Trust.

22. The prison is divided into two main areas. The upper prison contains four wings (G-K) which include the First Night Centre and the induction wing. The lower prison has five wings (A-E). The man was located on B wing. B wing is split into two halves, commonly known as the inner and outer. The wing operates as a voluntary drug testing Unit (VTU) for prisoners who wish to live in a supportive environment away from drug use.

Previous deaths at Manchester

23. The man was the sixth prisoner in Manchester to apparently take his own life in two years. There have since been a further three prisoners who have died, apparently by their own hand. The Ombudsman's office has previously recommended that screening for self-harm and suicidal tendencies should be undertaken at reception following a prisoner's arrival from court.

Cell sharing risk assessment

24. A Cell Sharing Risk Assessment (CSRA) is opened by a reception officer who completes the basic details. The form is handed to the First Night Centre staff who conduct a confidential interview. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells. While primarily used to assess cell sharing, it also includes other occasions when a cell may be shared, for example if a prisoner requests the assistance of a Listener. (Listeners are prisoners trained by the Samaritans.)

Prisoner mail

25. There are no restrictions on the mail that prisoners can send or receive. The staff in the post room have clear instructions about their responsibilities, although none have received specific training. All incoming and outgoing mail is opened and checked for enclosures or unauthorised articles, and 5% of letters (both incoming and outgoing) are read. There are also separate lists of prisoners subject to public protection or security monitoring, and these prisoners' mail is forwarded to the relevant department.

Suicide and self harm monitoring

26. Assessment, Care in Custody and Teamwork (ACCT) is the system used by prisons in England and Wales to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is supervised at regular intervals according to the perceived level of risk.

27. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people, forming a case review team, who know the person at risk or are involved in their care. The key questions for each review are listed as:

- Have the problems that caused the ACCT plan to be opened now been resolved?
- If not, what needs to be done to resolve them?
- Have any further problems arisen that are now causing distress and more risk?
- If so, what action can be taken to address these?
- Is the person at risk now in contact with friends, family or other support?
- Does the person at risk now have something in their lives that they feel good about?
- If not, how can this be improved?

28. Over time, the reviews should also consider other factors such as:

- Distress – has anything changed to make the person at risk more or less desperate?
- Resources – has anything changed that makes the person at risk now feel more or less alone?
- Previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
- Suicide intention or plan – has anything changed to show that the person at risk is either more or less prepared to kill themselves?
- Pattern of self harm – is self harm becoming more or less frequent?

29. An ACCT plan can be opened by anyone working in the prison. An ACCT should be opened when anyone has any concerns whatsoever that a prisoner may be at risk of harming him or herself. Among other things, the ACCT guidance states that prisoners should be cared for in a safe environment and the case review team decide the most appropriate place to locate an individual prisoner.

30. Once it has been agreed that ACCT support is no longer required, a post-closure interview must be held to ensure that problems have been resolved or reduced and that the level of risk has sufficiently dropped. The date for the interview is a matter for the case review team to decide, but it must be within seven days of the ACCT support coming to an end.

Reception process

31. Reception staff should deal with prisoners in a sensitive and respectful manner, taking particular care to put first time offenders at ease. After being checked in at the desk prisoners are placed in holding areas, whilst awaiting private interview. New prisoners' immediate anxieties are discussed and dealt with at this time. Prisoners are seen by an interviewing officer and nursing staff where any medical needs are assessed, vulnerable prisoners are identified, an Assessment, Care in Custody and Teamwork (ACCT) document may be opened, and a plan for immediate care is formulated.

Safer cells

32. Safer cells are specifically designed to contain fewer ligature points than ordinary cells. They also contain furniture which is designed to minimise the potential for self harm rather than removing it altogether.

33. Prison Service Order (PSO) 2700 deals with suicide prevention and self-harm management. The PSO says that "when considering where to locate an at-risk prisoner consideration must be given to whether the prisoner will benefit from allocation to a safer cell or other supportive location".

Her Majesty's Inspectorate of Prisons' report

34. The last report published on Manchester by HM Chief Inspector of Prisons (HMCIP) followed an announced inspection in July 2009. The report found that:

> "Manchester is a complex and large prison, which needs to manage a varied population… It is commendable that it has managed to retain its local prison focus, and to provide purposeful activity for a large number of prisoners, while holding securely its category A prisoners… More fundamentally, managers need to explore and remedy the lack of trust between some staff and prisoners, building on the strong relationships in some parts of the prison to ensure that interactions are both appropriate and positive."

35. The 2009 HMCIP report found that "The safer prisons strategy was comprehensive. The safer prisons team met regularly, although not all areas were represented. Assessment, care in custody and teamwork (ACCT) procedures were monitored and booklets generally well completed. Not all staff had received refresher training. There were not enough care suites and there was reluctance from some night staff to ensure that prisoners received the support of a Listener." (Listeners are prisoners trained by the Samaritans. Conversations between Listeners and other prisoners are confidential.)

Independent Monitoring Board (IMB) report

36. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the community, appointed by the Secretary of State for Justice. The IMB is responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB for Manchester covers March 2008 to February 2010 and stated that:

> "A more stringent quality control of comments in ACCT documents would result in a more meaningful document which would in turn be more informative at the review stage… ACCT documents are not always of a meaningful, professional nature. The regularity of comments in ACCT documents is also of concern given the often extended time-gap between comments."

KEY EVENTS

37. The man was arrested on 29 October 2010, and charged with burglary and taking without consent. He was granted bail. At the time, he was also on bail for a separate charge of assault. When he attended at a magistrates' court on 19 November, he pleaded guilty to the charges of burglary and taking without consent, and was sentenced to eight months imprisonment. This was the man's first time in custody.

38. When prisoners are moved between different areas of custody, they are accompanied by a person escort record (PER). The PER form completed for this man's transfer from a magistrates' court to HMP Manchester shows that he had recently harmed himself. A suicide/self-harm warning form was completed to make staff aware that he might be at an increased risk of attempting to harm himself and that he was to be checked intermittently. It was noted on the form that he said that he felt "fine".

39. Additionally, the court faxed a copy of the man's pre-sentence probation report to HMP Manchester. It is not clear in which area of the prison this fax arrived, but it was not seen by reception staff.

40. On arrival at Manchester, the man saw a nurse who carried out the reception health screening. She saw the PER and suicide/self-harm warning form. The man told her that he had seen a doctor in recent months in relation to depression. He also said that he had taken an overdose due to the breakdown of his relationship with his long-term partner and consequent problems in his relationship with his children. He said that he now felt fine. The nurse said in interview with the clinical reviewer that she had no concerns about the man, and she made a note on the prison file that there were no concerns over him harming himself. She also had no concerns over his mental health. There is a protocol in HMP Manchester that newly arriving prisoners who have previously harmed themselves should be referred to the mental health team for assessment. This man, however, was not referred. He was not on any prescribed medication, so in line with usual practice, his outside doctor was not contacted for previous records.

41. As part of the health screening, the nurse conducted a cell sharing risk assessment (CSRA). She assessed the man as presenting low risk of harm to a potential cellmate, and that he could be allocated a shared cell. The section of the form asking whether the PER or accompanying documents provided evidence of previous behaviour relating to self-harm is marked "no". He was located on the induction wing, G wing.

42. Separately from the offences for which he was imprisoned, the man was on bail for other suspected offences. One of his bail conditions was that he should not contact his former partner. This is noted on the printout of his Police National Computer (PNC) record which forms part of his prison file.

43. As part of the induction process, prisoners have the opportunity to speak to a member of the chaplaincy. The man saw a member of the chaplaincy. He asked the chaplain if he would contact his partner for him. The chaplain did so, but the man's partner was still angry with him and told the chaplain that she would not be visiting him in prison. The chaplain did not pass this message on, but did let the man know that he had made contact.

44. The man had a routine secondary health screening on 22 November. No concerns were noted in relation to his mental health.

45. The man spoke to his former partner on the telephone on 24 November. They argued and the man said he was thinking of hanging himself. His former partner, however, remained extremely angry at the situation that had arisen and did not express sympathy. She replied that he was not going to see her or their children again. He telephoned her again that afternoon, and she said that she was intending to take out an injunction to stop him from contacting her. He repeated his claim that he was going to hang himself. Amid a heated conversation, she told him to "stop phoning me and go and do it". The investigator has listened to the recordings of a number of telephone calls between the man and his former partner, and such an exchange between them was not unusual.

46. On the morning of 25 November, a probation administrator in the prison sent an email to the safer custody office. She provided a suicide risk template, which noted that during the man's pre-sentence report interview on 11 November, he had disclosed his recent act of self harm. The probation administrator wrote that she thought that the man would benefit from a post-sentence review to assess the impact of being taken into custody. She also completed a security information report with this information. The information received was shared with the security department and the manager of G wing.

47. The probation administrator then telephoned G wing and spoke to an officer. She gave a brief account of the contents of the man's suicide risk form. The officer told the senior officer what she knew, and he asked a further officer to speak to the man to assess the risk of him harming himself. The officer did so, on the morning of 25 November. He did not recall being given any background as to why. They spoke at length. The man explained that earlier in the year, whilst experiencing problems in his relationship, he had cut his wrist and taken an overdose of prescription drugs. He said that he would not try to hurt himself again: he wanted to stay in contact with his children, and only had 13 weeks of his sentence remaining. The man had not long spoken to his children, and the officer noted this had put him in good spirits during their conversation. The man was laughing and engaging fully in the conversation. The officer reminded him that the Listener service was always available (as mentioned above, Listeners are prisoners trained by

the Samaritans to provide confidential support to other prisoners) but had no concerns that the man was at risk of harming himself.

48. In the afternoon the man received a legal visit. He made fifteen telephone calls through the course of the day, ten of which were to his sister and five to his ex-partner. It appears that he had a five-minute call with his sister, and two of the calls to his ex-partner lasted a few minutes. The rest of the calls were unanswered. In the first of the connected calls, his ex-partner asked him not to phone her or write to her again. In the second call, he asked if he could send a visiting order, to allow someone to bring his son to visit him at Christmas. His ex-partner agreed, but told him not to put her name on the order.

49. The man was due to have a visit from a friend on this day. In the event, however, the visit did not take place.

50. The man received another letter, dated 28 November. The letter does not show who sent it, but was critical of the mistakes that the man had made in his relationships, and mentioned the unhappiness he had caused his ex-partner and children.

51. On 1 December, the man moved from the induction wing to B wing. There is a prisoner peer support group on the wing, and as part of his induction there he spoke to one of the members of the group. As part of this induction he spoke to his ex-partner on the telephone to inform her of his move. During the call she confirmed the end of their relationship. She said that she had moved on, and now she had met someone else. In the course of the conversation, she again said that she intended to take out an injunction to stop him from contacting her. It was a stormy telephone call, and once more the man indicated that he was going to harm himself. His former partner said “Go and do it then”. She terminated the call.

52. In light of this telephone call, the man was visibly upset. His peer supporter told a senior officer what had happened, and they brought him into the wing office. The man was distressed and tearful, and relayed what his ex-partner had said. The senior officer confirmed in interview that she did not think that the man was likely to harm himself imminently, but that he needed some support. She took the decision to place the man on the support provided by Assessment, Care in Custody and Teamwork (ACCT), and she opened an ACCT plan there and then. The plan was opened at 3.30pm. Staff would have significant interaction with him at least four times during the day, and to observe and check on him at least four times during the night. It was also agreed to put him in a shared cell with a mature and experienced prisoner who would provide him with a level of support.

53. One of Manchester’s trained ACCT assessors was next on the staff rota when the man’s ACCT plan was opened. Whilst carrying out her duties on G wing, she was informed that the ACCT plan had been opened. She

went to B wing at 6.45pm to carry out an assessment interview. This was done jointly with a senior officer. The man said that his previous act of self-harm was a cry for help when his ex-partner would not talk to him and he wanted her attention. Prior to the phone call earlier that day, things had seemed okay. He had received a letter from her some days earlier and there did not appear to be any problems. He said that he was eating well, but having trouble sleeping because he was thinking about his family. It was recorded in the ACCT plan that he did not want to die and had no intention of harming himself. He planned to get work on release from prison, wanted to be involved in his children's lives, and seemed positive for the future. He mentioned that he did not have any accommodation on his release, so a referral was made to the department who could help him seek housing. The ACCT assessor said that the man did not seem particularly comfortable with approaching staff, so having the ACCT plan open would make interaction happen and give him the opportunity to be supported without having to seek support. It was agreed that the ACCT plan would remain open whilst he settled onto B wing. The ACCT assessor ensured that the man fully understood the access he had to Listeners and the Samaritans. He was told that he was also able to discuss his situation with someone from the chaplaincy if he wanted to.

54. Part of the ACCT process is the production of a care map. This sets out the issues the prisoner faces, and provides goals and actions which will provide support. The man's goals were to keep in touch with his children, to go to full time education, to arrange contact with the housing department, and to make a phone call to his ex-partner. Staff were to have at least four meaningful interactions per day with him, and were to check on his wellbeing at least four times during the night. A review was scheduled for 8 December.

55. The ACCT document contains an ongoing record, which includes notes of observations as well as any significant events and conversations. The man's ongoing record covering the following days shows that in education classes he was working hard and had a very positive attitude. He was engaging with his peers during association (periods of free time where prisoners can interact with each other), and he had written a letter to his daughter. On 6 December, he lost his temper in a class, the reason for which was not known. He quickly calmed down, and thereafter continued to work well.

56. The man received a legal visit on 7 December. He made a telephone call to his former partner at 2.05pm on 8 December. During the course of the conversation she told him that he was not allowed to speak to her. He called back at 2.10pm, and again his former partner asked him to stop telephoning her.

57. A review of the man's ACCT was held at 3.00pm on 8 December. The original SO who initially opened up the ACCT was not on duty, so a further SO acted as case manager. As well as the man himself, an

officer and a member from the chaplaincy also attended. No new issues were identified during the review, and the man was recorded as being at low risk of harm. The case manager noted that during the interview the man was very chatty and seemed to be in a very upbeat mood regarding his situation. He had not yet spoken to his ex-partner since their last conversation, so it was agreed that the ACCT plan should remain open until he had contacted her: until this happened it would not be possible to gauge how he would react. The next review was scheduled for 15 December.

58. On 9 December, the man telephoned his former partner. During the conversation he asked her if she would write to him. She replied that he was not allowed to write to her, she was not allowed to write to him, and they were not allowed to speak to each other.

59. Prisoners are allocated a personal officer, who will act as first port of call for information and from whom prisoners should seek advice if they need to. On 11 December, the man's personal officer noted that he seemed to be in a better frame of mind than he had recently been. The man's co-defendant had moved onto B wing. They had been friends for some 18 years, and spent a good deal of time together. On 13 December, the man and his co-defendant were moved into a shared cell. The co-defendant told the investigator that the man was more able to deal with his problems when out of the cell, but would dwell on his situation when they were locked up.

60. The next case review of the man's ACCT plan was held on 15 December. The SO who had initially opened up the ACCT was the case manager. Along with the man, an officer and a member of the chaplaincy also attended. The man was talkative and engaged well with the meeting. He had spoken to his ex-partner during the week, but did not go into great detail about what had passed between them. The case manager noted that the call had obviously affected him. The man said that he was concentrating on getting through Christmas. He was trying to maintain some contact with his daughter, but had not received any more letters from her. The chaplain recalled in interview that nobody thought that he was at risk of harming himself, and the officer said in interview that the man did not want to remain on the ACCT plan. It was thought, though, that he would benefit from continued support over the Christmas period, particularly in case his situation as regards his former partner and their children should change. It was agreed that the ACCT plan should remain open. The level of observation remained unchanged, but the next review was scheduled for two weeks, 29 December.

61. On 16 December, the man had a telephone conversation with his daughter. He asked to speak to his former partner, but she relayed through her daughter that she was not allowed to speak to him or visit him.

62. The man continued to receive correspondence. His sister sent him a letter dated 17 December in which she discussed arranging accommodation for him on release, and the two of them visiting a friend. She ended the letter encouraging her brother to stay strong. A friend wrote to him on 18 December, passing on various pieces of news and saying they would continue to write to him. In interview, the man's co-defendant said that the man also received correspondence from his former partner, confirming their split.

63. During the afternoon of 18 December, the man approached the wing office and spoke to an officer. He appeared to be very agitated, and demanded to see an officer who had told him to go and get his prison identity card. The officer had only just entered the office and tried to establish what he was angry about, but he stormed off. The officer made a note of the man's behaviour in his ACCT plan, noting him to be rude and aggressive.

64. The man's phone record shows that he made nine telephone calls throughout the course of 18 December. One short connected call was to his sister, there were four unanswered calls to his ex-partner, and four calls to another number which included one short connected call.

65. The following day, 19 December, an officer went to speak to the man to check on his wellbeing. He told her that he had been trying to speak to his daughter, but that his ex-partner was not answering the telephone. The officer asked whether he should write a letter, but he said three letters had gone unanswered. She suggested that he should try another telephone call on Christmas day as he might have more success then. He seemed a little low and stated that he had not had any contact or any upcoming Christmas visits from his family as they were "busy with lots to do". He said that his sister had been intending to bring his children in to visit him, but was concerned that his ex-partner would not allow her to do so. He said that he felt low, but the situation was not new. He understood why his ACCT plan remained open, but said that he would like it closed. He said he had no thoughts of harming himself.

66. Records show that over the next few days the man's mood seemed to improve. He participated well in his education classes. A note on his ACCT plan shows that, on 22 December, he received a letter that he hoped indicated an upturn in his private life, although records do not show who this was from. He said that he hoped to talk to his daughter on Christmas Day. Phone records show that he made ten telephone calls that day, which included two long conversations with a female friend, and a connected call to his sister. In one of the calls to his friend, he mentioned that his former partner had sent him "a daft letter, telling me to go hang myself".

67. The following day, 23 December, the man made ten telephone calls. Nine of these were to a female friend, with one conversation of 15 minutes and another of five minutes. The other call was an unanswered

call to his sister. A note in the man's ACCT plan shows that he had spoken to a female friend on the telephone and that he was in good spirits. The next day he made ten telephone calls, including four unanswered calls to his ex-partner, a five-minute call to a female friend, and a five-minute call to his sister.

68. An officer spoke to the man at 5.00pm that evening. The man said that he was fine, but appeared to be agitated. The officer made a note in the man's ACCT plan recommending that staff should monitor him for "the next couple of hours to ensure he is ok".

69. Another entry was made in the man's on-going record at 8.10pm. He appeared to be in good spirits, and had been provided with stationery, which pleased him. He said that although he did not expect to be able to, he would still try to speak to his daughter the following day.

70. The man did not collect his lunch on 25 December and stated that he was not hungry. A senior officer spoke to him at 2.55pm, and he told her that he had been unable to speak to his daughter. He was very upset, and told her that he did not know what to do. They had a long conversation, and the senior officer suggested some possible ways forward. Towards the end of the conversation the man was more upbeat and he said that he would tidy himself up and go out on association. She told the man that if he needed anything he should speak to her or another member of staff.

71. At 8.10pm the man told a member of staff that he would not be able to speak to his daughter that day, and he felt a bit low. He mentioned that he also still needed to sort out his release accommodation. A scheduled housing interview had recently been cancelled, and he wanted it rescheduled to help with his potential release in January.

72. The next day, the man made two telephone calls. One was to a female friend's number and was unanswered, and the other was a one-minute call to his ex-partner's number. His ongoing record contains an entry at 12.00pm noting that, although he said he was okay and was smiling, he appeared to be subdued. Later that evening he said that as he had been unable to contact his daughter, he was going to write to her. He seemed to be in better spirits.

73. The man's cellmate, however, said in interview that at about 8.00pm on what he thought was 26 December, the man came out of the cell toilet. He looked shaky, and showed his cellmate that he had caused cuts to the inside of his forearm with a razor. His cellmate took the razor from him, washed his arm, and said that he was going to tell staff. The man asked him not to. He told his cellmate that he wanted to come off ACCT support, and if staff knew that he had cut himself, that would not happen. In something of a dilemma, the man's cellmate decided to abide by his friend's wishes and did not tell anyone what had happened. He sat and spoke with him, and tried to help him look forward to being out of prison.

74. On 27 December, the man made ten telephone calls. Nine of the calls were to his ex-partner, all of which were unanswered apart from the last, which connected for thirty seconds. The remaining call, also unanswered, was to a friend's number.

28 December 2010

75. Tuesday 28 December was a bank holiday. Prisoners were not required to work, and were given extended periods of association.

76. A note in the man's on-going record at 10.00am says that he had been out on association and was in a good mood. His cellmate, though, told the investigator that whilst he himself had gone out on association, his friend had stayed in bed. From time to time he went back to the cell to try and encourage him to come out and associate, but the man said that he was tired and wanted to stay in bed. His cellmate did not think that he seemed particularly upset or depressed, just that he wanted to stay in bed.

77. The SO on duty that day noticed that the man had spent the morning in bed, and he had checked in on him a few times. There were no apparent problems. He looked in on him again at lunchtime, and thought that he appeared to be in a good mood. The SO noticed a sandwich in the cell and made a note on the ACCT plan that the man had collected his lunch. His cellmate, however, said that despite his encouragement, the man had not collected his lunch, saying he was not hungry. The SO said in interview that he only saw food in the cell, and it was possible that it had been there from a previous occasion.

78. Once they have collected their meals, prisoners are locked in their cells through the lunch period, from approximately 12.15pm. The man's cellmate ate his own lunch, then lay on his bed with his eyes closed, listening to music on one of the television channels. He could hear the man walking around the cell and assumed he was getting dressed. After a while, he opened his eyes and the man asked him if he was alright. He said he was and returned the question, and he said he too was alright. The man then went into the cell toilet.

79. The man was in the toilet for some time and after approximately fifteen minutes his cellmate called out to him to see if he was alright. There was no reply. The man's cellmate said in interview that it was not unusual for his friend to withdraw into the cell toilet for reasonably long periods. It was somewhere he could get privacy if, for example, he became upset and did not want to show his feelings. When the time was approximately 1.30pm, the man's cellmate rolled a cigarette. He smoked half of it, then called out to his friend that he had half a cigarette for him. There was no answer, and he assumed that his friend was upset. He put the cigarette in the ashtray, and waited another five minutes. He then called out again, still receiving no reply. He knocked on the door, waited, then

knocked again. Not receiving an answer, he pushed the door slightly open, and could see the man's feet on the floor by the window, as if he were sitting on the pipes on the wall. His cellmate asked if he was alright, and did not get a response. He pushed the door open further and looked in. At this point he realised that the man had a ligature made from a bed sheet around his neck. His skin was discoloured, and he had foam around his mouth. He was not moving, and his cellmate formed the impression that he was dead.

80. The man's cellmate came back into the main room of the cell, and pressed the emergency call bell. Records of when the emergency bells are activated are not kept. The man's cellmate said that at the time it seemed like some minutes before staff arrived, but an officer remembers that he was on the landing when the alarm went off and made his way directly to the cell. He estimated that he was at the cell within a minute. He asked what was wrong, and the man's cellmate said "You need to have a look in there" and indicated the toilet area. The officer went into the toilet, and the man's cellmate went out of the cell and sat on the stairs on the landing.

81. When the officer opened the toilet door, he saw the man hanging by a bed sheet. He took a hold of the man and lifted him to relieve the pressure on his neck, and called for urgent assistance on his radio. The call went over the radio network at 1.40pm. Whilst continuing to support the man's weight, he also shouted for help and some 30-60 seconds later a senior officer arrived. The senior officer began to remove the ligature and found that it was not tied but looped around the man's neck. Possibly because the officer was supporting the man, it was not tight and he removed it with little effort. The man's body was warm but his skin was pale. The senior officer could not detect the man breathing, and he was not responding to being spoken to. He shouted for a defibrillator (a machine to send electrical rhythms to the heart), and began to perform cardiopulmonary resuscitation (CPR – consisting of chest compressions and airway management). A further officer and a Developing Prison Service Manager (DPSM) had by this time arrived and, because of the limited space in the toilet area, the officers moved the man to the main area of the cell. The senior officer continued to perform chest compressions, while the officer who had originally discovered the man administered rescue breaths (formerly referred to as mouth-to-mouth resuscitation).

82. Other staff were still responding to the emergency call, and at 1.42pm a further senior officer requested an ambulance. Staff were sent to the prison gate and the entrance to B wing so that the ambulance could be escorted through prison security without delay. A healthcare senior officer and a further senior officer collected the emergency bag and defibrillator and brought them to the cell. Two nurses arrived at the cell and one of them took over the chest compressions. The defibrillator pads were attached to the man's chest and the defibrillator advised that cardio pulmonary resuscitation (CPR) should be continued. The

healthcare senior officer then took over chest compressions and one of the nurses administered oxygen. The other nurse tried to insert a tube into one of the man's veins so medications could be administered to him, but was unable to find a vein strong enough. Another cylinder of oxygen was requested, and brought across from the healthcare centre at 1.46pm.

83. At 1.50pm a member of the healthcare staff told the DPSM that the man had no pulse. The locum doctor and Sister were by this time in the cell, and the Sister assisted the nurse in administering oxygen and keeping the ambubag (a medical device to aid breathing) in position over the man's nose and mouth.

84. With an ambulance having been called, a first-response paramedic arrived at the prison at 1.50pm and was in the cell three minutes later. He told staff to continue CPR whilst he administered adrenaline. The paramedic was also unable to gain access to a vein using a needle, and had to form an opening through a bone in the man's leg to get the adrenaline into his system. The paramedic then applied his own defibrillator, which detected a heart beat. Chest compressions were stopped and his pulse was monitored, while oxygen was still administered. Approximately ten minutes later he began to take some breaths unaided.

85. The paramedic and staff continued to provide first aid to the man and the second ambulance arrived at 2.24pm. Two paramedics arrived at the cell and helped to prepare the man for transfer to hospital. He was moved onto a stretcher and at approximately 2.46pm was taken out to the ambulance. At this stage he was breathing 75% on his own, and equipment on the ambulance replaced manual oxygen assistance. Two officers escorted him in the ambulance. No physical security restraints were used, and he was accompanied by two prison officers. The ambulance left the prison at 2.51pm and arrived in outside hospital at 3.05pm.

86. After leaving the cell, the man's cellmate waited on the landing. An officer spoke with the cellmate, who stated that he was fine, but that he did not want to go back to the cell that night. He was then located with a Listener and offered the opportunity to use the care suite (a facility for prisoners who have undergone a potentially upsetting experience), which he declined.

87. At 3.50pm, a member of the chaplaincy attempted to contact one of the man's sisters, who was recorded as his next of kin. He telephoned the number which he thought was for the man's sister. In fact, it was the number for the man's ex-partner. The chaplain said that he needed to speak to the man's sister. She asked if it was about money, but the chaplain reiterated that he needed to speak to the man's sister. The man's ex-partner then said "Oh no, has he done something?" The

chaplain asked again for the number of the man’s sister, but his ex-partner said that she did not have it.

88. The chaplain contacted an officer and managed to obtain the man’s sister’s telephone number. He called her at approximately 4.05pm and told her that her brother had been taken to hospital. The man’s sister became extremely upset, and passed the phone to a friend who was with her. The chaplain gave him the telephone numbers for the hospital switchboard and the accident and emergency department.

89. At 4.45pm someone contacted the control room at Manchester and said that she was the man’s sister. She asked for some information on her brother but as she was not listed as next of kin, staff told her to contact his other sister for information.

90. The man was taken for a computed tomography (CT) scan (a specialised X-ray test to give clear pictures of the inside of the body, particularly of the soft tissues) at 4.50pm. This took approximately twenty minutes, when he arrived back in the accident and emergency unit, his family arrived. He remained unconscious and hospital staff prepared to move him onto a ward.

91. At 7.20pm the man was moved to the intensive care unit (ICU.) The bedwatch officers (the prison staff who accompany a prisoner to an outside hospital) sat outside the unit to give the man and his family privacy. Restraints had not been applied to the man at any time due to the severity of his condition.

92. Over the following days, the man received visits from his family. On 29 December, his family told prison staff that under the terms of his bail, his former partner was not allowed to visit him. After confirming this, the prison’s security department told the bedwatch staff that this was the case. She, along with their daughter, arrived at the hospital that afternoon. She was refused entry, but waited outside the unit whilst her daughter visited.

93. Staff were made aware of possible tension between some of the man’s family and his former partner. Bedwatch officers were issued with radios, and hospital security staff remained alert to the possibility of any difficulties, but none transpired.

94. A member of the chaplaincy staff visited the man in hospital on 29 December. He introduced himself to the man’s sister, and they discussed his condition. She said that she knew that her brother was going to do something as he had written and said he would and she felt that there was nothing that anyone could have done to stop him. She thought that he had chosen his time carefully so that staff would be on their lunch break. She had no concerns with how the prison had treated her brother and was aware that he was on an ACCT plan. She was upset that his ex-partner was not allowed to see him and asked the

chaplain to inform the Governor of this. She was also concerned about her brother's cellmate and asked that staff were watchful of him. Before leaving, the chaplain said prayers at the man's bedside.

95. The following day the Probation District Manager in the prison contacted the prison's security department and a variation was subsequently made to the man's bail conditions to allow his former partner to visit. Later that day, she did so.

96. On 31 December, staff at Manchester began the process of releasing the man from prison on temporary licence. Arrangements were put in place to collate the necessary papers.

97. During a morning in early January 2011, the man's condition began to deteriorate. Hospital staff spoke with his family about withdrawing his life support, and with their agreement the machines were switched off at 12.00pm. The man was pronounced dead at 12.09pm.

98. The man's family were present at his bedside, although his ex-partner was unable to reach the hospital before he died. The family were complimentary about the bedwatch officers and how they had conducted themselves towards the family. The man's sister requested that the chaplaincy should tell his cellmate of his death. As bedwatch staff left the hospital, there appeared to be some animosity from the family towards an unidentified person, but the situation did not escalate.

99. A Developing Prison Service Manager (DPSM) was appointed as family liaison officer, and he and a member from the chaplaincy went to the hospital. They arrived at 2.20pm, but were told that the family had left. They returned to the prison and the chaplain telephoned the man's sister and arranged to visit her the following afternoon. The prison chaplain then went to the man's cellmate and told him that his friend had died.

Debrief

100. It is usual following the death of a prisoner to hold a debriefing session with staff involved in his or her care. These ensure that staff have an opportunity to discuss any issues arising, and for support to be made available.

101. In the case of this man, although he was still alive when he left the prison, a hot debrief was held on 29 December involving staff who had attended the cell and provided assistance. Staff were told that they had done a good job and that everyone had played a big part in trying to save the man's life. They were advised to make notes of their involvement while it was fresh in their mind to enable them to make a comprehensive statement. Staff were invited to talk in turn about their involvement and any issues that they had. A general issue raised by staff was regarding the new locks that had recently been installed on cell doors. The new locks made it extremely difficult to get in during an emergency, especially

if carrying emergency equipment as you need two hands to operate the locks. The IMB members also raised the time it took for an ambulance to arrive, although the first response paramedic had arrived within a short period of time following the initial 999 call. Uniformed staff who had provided first aid to the man were telephoned at home to check on their wellbeing and/or visited in the office by staff care and welfare.

102. Following the man's death, a further debrief was held chaired by a Governor and involving the two officers who were on bedwatch with the man when he died. The Staff Care Team were also present. No issues were reported relating to the time the man spent in hospital. His family had been complimentary about the staff on bedwatch, which had helped those officers cope with the situation. The man's ex-partner had been contacted before he had died, but had been unable to make it to the hospital in time. Prison records do not show who contacted her but staff thought it may have been someone from the hospital.

Support for prisoners

103. When informing him of the man's death, the prison chaplain spent some time with the man's cellmate. The man's cellmate confirmed in interview that he received a good level of support from staff, a number of them speaking to him at the time and subsequently to check on his wellbeing.

104. A service was held in the prison chapel for the man's family. Prisoners did not attend, with the exception of the man's cellmate. Some two weeks after the man had died, another service was held to allow prisoners to pay their respects.

Support for staff

105. Support was made available to staff at both debriefs. Staff were aware that they could continue to seek support if they felt that they needed to.

Post mortem

106. A post mortem was carried out on 2 January 2011. The post mortem concluded that the man's death was due to pneumonia caused by brain injury as a result of hanging.

Funeral

107. The prison offered to make a contribution towards the cost of the funeral. They also asked the family if they could be represented there, to which the family agreed. Two members of staff attended the funeral, which was held on 18 January.

ISSUES

On reception

108. The man arrived in Manchester with his PER form showing that in recent months he had cut himself, taken an overdose, and consulted a doctor in relation to depression. These papers were available to the nurse who conducted his reception health screening, yet on his reception records the section asking about concerns over self-harm are marked "no".

109. The nurse had no concerns over the man's mental health, nor did she think that there was a current risk of self-harm which would have merited the opening of an ACCT plan. Clearly this required a professional member of staff to make a judgement. This investigation accepts that she made these decisions based on her training and experience.

110. It is unlikely that had an ACCT plan been opened for the man on reception, this would have saved his life. There is no evidence that he harmed himself before the ACCT plan was eventually opened. Moreover, the plan remained open at the time he managed to harm himself to the extent that he ultimately, some days later, succeeded in taking his own life.

111. There was, though, clear evidence that the man had harmed himself recently prior to coming into prison and had been treated for depression. Although his behaviour was thought to be caused by emotional problems rather than symptoms from a mental health diagnosis, the prison's local protocol says that prisoners who have exhibited previous self-harming behaviour should be referred to the mental health team for assessment. This did not happen. The clinical reviewer notes that since the man's time in Manchester, an electronic system is now used for the reception health screening that would automatically make a mental health referral where a prisoner has a history of self-harm. In this man's case, however, his reception documents were not noted to the effect that he had a history of self-harm, so there is no guarantee that this would have been picked up even with the electronic system. The clinical reviewer notes that the man did not have a diagnosed mental health problem nor did he display any symptoms indicating the need for a referral to the mental health team during his time in prison. Nevertheless, the Head of Healthcare should remind reception staff of the importance of accurately recording information which arrives with prisoners.

    The Head of Healthcare should ensure reception staff are aware of the importance of recording information which arrives with prisoners.

112. When he had harmed himself earlier in the year, the man underwent a mental health assessment. He was not judged to have a mental illness, but had reacted to a situation. The clinical reviewer says that had he been assessed by the prison's mental health team, it is unlikely that he would have required treatment. We accept this, and again it does not seem that

it could have made a difference to the final outcome in his case. Nevertheless, a referral should have been made, and the Head of Healthcare should ensure reception staff refer prisoners with a recent or relevant history of harming themselves to the mental health team for assessment.

The Head of Healthcare should ensure reception staff refer prisoners with a recent or relevant history of self-harm to the mental health team for assessment.

113. The man had had recent contact with his doctor over depression. If a prisoner is not taking medication, it is not Manchester's practice to request copies of his medical record from his outside doctor. The clinical reviewer recommends that prisoners' medical records should routinely be requested where there is a previous history of the prisoner harming himself. This office agrees.

The Head of Healthcare should ensure systems are in place to routinely requesting the outside medical records of prisoners who have a history of harming themselves.

114. Although the probation pre-sentence and suicide risk report was faxed to HMP Manchester, it was not received by the healthcare staff in reception. The clinical reviewer recommends that systems should be in place to ensure that all information relating to concerns over a prisoner's safety are passed to reception. Once again, this office agrees.

The Governor should ensure that systems are in place whereby all information received relating to prisoner safety is available to reception staff.

Contact with his ex-partner

115. As well as the charges for which he was imprisoned, the man was also on police bail for other suspected offences. One condition of this bail was that he should not contact his former partner. Part of the man's prison file contains a printout from the Police National Computer (PNC) for the court, on which this bail condition is noted.

116. When the prison chaplain contacted the man's former partner at his request after he arrived in prison, she did not tell him that she did not want contact from the man or that contact was not allowed. She said that she would not visit. The man telephoned her on several occasions whilst he was in prison, and on a number of these occasions she made it clear that she did not want him to contact her, and that they were not supposed to be in contact. At no stage, though, did she contact the prison to ask that he be stopped from contacting her.

117. When the man spoke to his former partner on 1 December and she confirmed the end of their relationship, he did not make an attempt on his

own life even after having threatened to do so. This happened some weeks later, after he had been unable to speak to her or his children for some time. It appears that the spur for him to harm himself was not contact with his former partner but the lack of contact. Although they had some stormy and emotional telephone conversations, the last of these was some days before he harmed himself. It does not therefore seem that the contact with his former partner was the immediate stimulus for the man's actions.

118. Nonetheless, it remains the case that the man should not have been in contact with her. It is possible that some prisoners may arrive with bail conditions in place that the prison will not be aware of, and it is not reasonable to expect the prison to check with outside agencies for every prisoner who arrives. The presence of the PNC printout in the man's file, though, means that this information was available in this case. Even once he was placed on ACCT support because of difficulties in his relationship, the issues over contact were not considered. The Governor should review the systems in place and assess whether they are adequate to ensure that outstanding bail conditions are, where known, noted and acted upon.

The Governor should ensure that adequate systems are in place so that, where known, bail conditions for new prisoners are acted upon.

Management of ACCT plan

119. When the man received confirmation that his relationship was over, he was visibly distressed. Staff rightly opened an ACCT plan, and showed good consideration for his wellbeing. He was monitored at what seem to be reasonable levels. An entry on his ACCT plan on 28 December says that he was participating in association and was in a good mood, whereas his cellmate and the wing senior officer said that he did not get out of bed. Taking into account comments from his friend and cellmate it does appear, though, that he was keen to hide his real feelings from others. This may explain why staff were unable to accurately gauge his mood.

120. The man's family asked why he had removable bed linen and access to other articles which he could use to harm himself if he was on ACCT support. Sadly, if a prisoner wishes to harm himself, there are a number of ways that he can do so. It would not be reasonable to expect the prison to remove any possible means that a prisoner could use to harm himself. Moreover, to do so would be to remove some of the sources of dignity which prisoners rightly value highly. Unless there are specific indications that a prisoner may use a particular article to harm himself, or if a prisoner on an ACCT plan has used a particular item to harm himself in the past, this office does not think that it is realistic to expect the prison to withhold all items which a prisoner might feasibly use to harm himself.

121. This report notes that the case manager is different on each of the man's ACCT reviews. This is because when the second review was held, the case manager who had originally opened the ACCT was not on duty. It is

good practice for there to be a consistent case manager in ACCT reviews, and it may be that the scheduling of reviews can be set so that this is managed as far as is possible. Having said that, it must be accepted that staff do work shift patterns, and we would not want to see ACCT reviews delayed merely to allow the same case manager to attend. However, we also note that although the prison chaplain attended both reviews, the discipline officers who attended were also different. In addition, healthcare were not represented at either review. The investigator asked the original case manager why healthcare were not involved, and she said that the man was not under any mental health treatment, nor was he subject to any healthcare input at the time. She did not think that the fact that he was subject to ACCT monitoring necessarily meant that the mental health team should be involved. However, given that he had a history of harming himself, his personal relationship was breaking down and was on an ACCT for that reason, should at least have had the matter brought to healthcare's attention. The clinical reviewer agrees.

The Governor should ensure appropriate staff are present at ACCT reviews.

122. Shortly after Christmas, most likely on Boxing Day, the man cut his forearm with a razor. He showed his cellmate, who took the razor from him and helped him clean the cuts. His cellmate wanted to tell staff, but the man asked him not to. He wanted to come off ACCT support, and knew that if staff discovered that he had harmed himself, they would keep the ACCT plan open.

123. We have considered whether staff could be expected to have noticed this. Under normal circumstances, we would hope that someone would have noted a prisoner on ACCT support having harmed himself. However, the man seemed to be determined to hide his feelings. His cellmate said that when they were locked up in their cell, his friend would brood on his situation and be upset. When he was out on the wing, however, he presented a stronger front. Whether this was because he could occupy his mind with other things, or whether this was just a show, we can not know. It does, though, mean that it may have been more difficult for staff to judge his precise feelings.

124. One of the man's sisters told us that she and her brother's other sister telephoned the prison and expressed concern that he had indicated that he had ideas of taking his own life. He had said in a telephone call that he had cut his wrist or wrists. She asked us what the prison had done with this information.

125. The prison had no record of these calls coming through. Calls such as this would usually be directed to the Safer Custody office, or as a back-up to the chaplaincy. There were, though, no records of such calls coming through to either department.

126. Obviously the receipt of such information should be treated seriously. This is particularly the case where the prisoner is subject to ACCT monitoring. In this instance, we are unable to trace where the calls went so cannot reach a conclusion on this point.

Safer cells

127. PSO 2700 instructs that staff should consider whether prisoners on ACCT support should be placed in a safer cell. In addition, Manchester's local Suicide Prevention and Self Harm Management policy (dated July 2009) says that staff should, when deciding a prisoner's location, consider:

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

128. When the man's ACCT document was opened, staff did consider his location. It was not thought that his current cellmate was appropriate, so changes were made and the man was later moved into a cell with his co-defendant, with whom he had been friends for many years.

129. Although he was subject to ACCT support, at no point did staff think that the man was at imminent risk of taking his own life. Leaving him on normal location, on a wing which contained other prisoners from his home town, and in a cell with a friend of longstanding seems to have been a reasonable decision in these circumstances.

Response to emergency

130. When it was brought to staff's attention that the man had harmed himself, it seems that the response was swift and professional. An ambulance was called without delay, and staff were deployed to security gates to ensure it could move swiftly through the prison. Staff tried hard to save the man's life, and it is a tribute to their efforts that he left the prison alive.

131. We do ask, though, whether there is enough clarity amongst staff as to the radio calls which indicate an emergency response. We would stress that there did not seem to be a delay in obtaining assistance, but from statements and interviews it does seem that staff were unclear on the code that should be used to indicate an emergency. We understand that protocols are in place in the prison to identify medical emergencies over the radio, and recommend that the Governor remind staff of the correct radio codes to use in the event of emergencies.

The Governor should ensure staff are aware of the correct radio codes to use in emergency situations.

132. Notes from the debrief show that staff had found it hard to enter the cell due to the new locks that have been installed on cell doors. This was

identified and is being addressed, and does not seem to have had any adverse effect in this instance.

133. An officer was trained to use a defibrillator, and the machine was quickly brought to the cell when called for. In the event, healthcare arrived before the officer applied the machine, but we are reassured that this was available to him.

134. We note from interviews that staff do not as a matter of course carry mouth shields. Staff worked very hard to keep the man alive, and the lack of mouth shields did not seem to affect the medical assistance given to him. Mouth shields are a small and inexpensive aid which offer protection to staff and mean that assistance can be given where needed without delay. We would urge that all frontline staff should be issued with mouth shields.

The Governor should ensure all staff who come into contact with prisoners have ready access to resuscitation mouth shields.

Informing the man's family

135. A prison chaplain was the member of staff who was given the responsibility for informing the man's family that he had been taken to hospital. The man's sister was listed as his next of kin, but there was no telephone number on the papers available to him. The prison chaplain therefore telephoned the man's ex-partner to ask for the relevant telephone number.

136. Contacting families with bad news is a difficult task. In this instance, there was tension between the various parties involved. We feel that it was unfortunate that the man's partner received an indication that there was a problem, when the correct telephone number was available elsewhere in the prison. We appreciate that there are sensitivities over prisoners possibly not wanting to provide outside contact details, but recommend that unless they are deliberately withheld, next of kin contact details should be noted on prisoners' records.

The Governor should ensure that, where possible, up to date contact details for next of kin are readily accessible.

137. There are two outstanding points raised by the man's family which this report has not so far addressed. They asked whether there was any evidence that the man was burning correspondence in his cell. No evidence has come to light to suggest this, and staff did not recall this happening. The man did say that he had received correspondence from his former partner, and none was found among his possessions so he may have disposed of them. There is no way of knowing, though, if, when or how he did so.

138. The man’s family also asked whether he had spoken to his former partner shortly before he harmed himself. Again, there was no evidence that this was the case. Prisoners were locked in their cells for the lunch period, and there is no indication on the man’s telephone record that he made any calls that day.

CONCLUSION

139. The man came into prison in November 2010, during a difficult period in his personal life. Following problems with his long-term partner earlier in the year, he had harmed himself, by cutting himself and taking an overdose, and had been seeing a doctor in relation to depression. His long-term relationship was under serious strain and it was his first time in prison. He was not thought to be at risk of harming himself, and was not referred for a mental health assessment. When a member of probation staff in the prison raised the issue of the man's previous self-harm, an officer interviewed him and concluded that he was not at current risk of harming himself.

140. As well as the offences for which he was in prison, the man was also on bail for separate offences. A condition of this bail was that he should not contact his long-term partner. Nevertheless, over the coming days he telephoned her a number of times. The calls were often tempestuous, and he indicated that he might harm himself. During heated discussions, his former partner did not try to dissuade him from doing so and on occasions retorted with her wish that he would. She indicated that they should not be contacting each other, but did not at any stage ask the prison to stop him from contacting her. On 1 December, she told him that she had met someone else and their relationship was definitely over. The man was visibly upset, and staff took the decision to put him on additional support.

141. The man remained under ACCT support from this point onwards. He presented a front which suggested that he was coping but his cellmate, who was also his co-defendant and friend, thought that he seemed to get more anxious as Christmas approached. Staff involved in monitoring him as part of the ACCT process did not think that he was at risk of harming himself, but thought that he would benefit from the additional support over the Christmas period. Shortly after Christmas, most likely on Boxing Day, he cut his forearm. His cellmate helped to clean his cuts, and wanted to tell staff. The man, however, asked him not to.

142. At lunchtime on Tuesday 28 December, whilst prisoners were locked in their cells, the man went into the cell toilet and used a bedsheet as a ligature. He was found unresponsive and staff made extensive efforts to resuscitate him, an ambulance was called, and he was still alive when he was transferred to hospital. He remained on life support for three days until, sadly, he died on a day in early January.

143. Broadly speaking, the man received reasonable support at HMP Manchester. He was appropriately assessed and monitored when he was thought to be at risk of harming himself. There are some issues around information recording. This report makes nine recommendations. These address:

- recording information at reception

- mental health referrals
- requesting of medical records
- the passing of information
- systems for noting bail conditions
- attendance at ACCT reviews
- emergency radio codes
- resuscitation mouth shields, and
- next of kin data.

RECOMMENDATIONS

1. The Head of Healthcare should ensure reception staff are aware of the importance of recording information which arrives with prisoners.

   NOMS accepted this recommendation. Refresher training will be undertaken regularly and audited by healthcare management.

2. The Head of Healthcare should ensure reception staff refer prisoners with a recent or relevant history of self-harm to the mental health team for assessment.

   This recommendation was accepted. NOMS say that the introduction of an electronic healthcare record system has made procedures more stringent to ensure that referrals are sent.

3. The Head of Healthcare should ensure systems are in place to routinely request the outside medical records of prisoners who have a history of harming themselves.

   In accepting this recommendation, NOMS said that a system has been put in place to ensure that relevant records are requested.

4. The Governor should ensure that systems are in place whereby all information received relating to prisoner safety is available to reception staff.

   This recommendation was accepted. NOMS commented:

   "The process by which information is received by the establishment and shared with reception staff or the safer custody team will be reviewed. A pilot process will be developed whereby a central fax will be identified and these details will passed to all the courts to ensure that they fax the information to the correct location within the establishment. If information then comes in at a later stage this will be forwarded to the Offender Management Unit who will highlight any details on the NOMIS system and inform the Safer Custody Team if necessary."

5. The Governor should ensure that adequate systems are in place so that, where known, bail conditions for new prisoners are acted upon.

   This recommendation was accepted. NOMS said that discussions have taken place with the prison's Custody Office to ensure that Police National Computer records are reviewed for any bail conditions. A process will be developed and tested.

6. The Governor should ensure appropriate staff are present at ACCT reviews.

NOMS accepted this recommendation. They commented:

"Clinical staff attend ACCT reviews if clinical input is required. All staff who have contact with prisoners are undergoing refresher ACCT training during which they will be reminded regarding appropriate and relevant staff attending ACCT reviews. This is reiterated in a Governor's Order that was published to this effect."

7. The Governor should ensure staff are aware of the correct radio codes to use in emergency situations.

   This recommendation was accepted. The Governor's Order regarding emergency radio codes was republished.

8. The Governor should consider ensure all staff who come into contact with prisoners have ready access to resuscitation mouthshields.

   This recommendation was accepted. NOMS commented:

   "Resuscitation mouth shields are available for all staff but guidance states that resuscitation masks should be used or just compressions are acceptable at least until equipment is available. Resuscitation masks are available in the suicide prevention kits on all the wings."

9. The Governor should ensure that, where possible, up to date contact details for next of kin are readily accessible.

   This recommendation was accepted. NOMS said:

   "Next of kin details are asked for in reception and noted within the core record. In addition to this the Chaplaincy department ensure all prisoners have an updated next of kin details during this induction interview, and note these on the NOMIS [electronic records] system."