



**Investigation into the circumstances surrounding the
death of a man
at HMP Stafford in January 2012**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Stafford who was found hanging in his cell in January 2012. He was 24 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer carried out a review of the man's medical care in custody on behalf of South Staffordshire Primary Care Trust (PCT). Stafford and the other two prisons where he had recently been, HMP North Sea Camp and HMP Lincoln, cooperated fully with the investigation.

During the last three weeks of his life, the man was returned to a closed prison, Lincoln, after he absconded from an North Sea Camp open prison, and was subsequently moved to Stafford, another closed prison. It is clear that he was upset by this turn of events and uncertain what the future held. Information and crucial documents were also not transferred between the prisons. When key documents were received by Stafford, they were not forwarded to the appropriate staff.

The man was assessed to be a risk of self-harm immediately before he transferred to Lincoln but a full assessment of this risk did not take place until after he had tried to end his life the next day. The investigation has found that suicide prevention arrangements were closed prematurely at Lincoln. Subsequently, Stafford failed to carry out a scheduled post-closure review. Overall, I agree with the clinical reviewer's conclusion that there was an over reliance on what the man told staff rather than a more holistic approach to his risk assessment. I am also concerned that, when the man's stepfather rang Stafford prison to tell them he was worried about his stepson's welfare, he was inappropriately told to put his request to speak to a governor in writing. The man was discovered hanging in his cell two days later.

It is impossible to determine whether, if procedures had been followed properly, the man's death could have been prevented. However, the management of his risk of suicide, as well as communication between prisons, staff, the man and his family could all have been handled better. Accordingly, a large number of recommendations for improvement are 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.

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Prisons and Probation Ombudsman

December 2012

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SUMMARY

1. The man received an indeterminate prison sentence for serious sexual offences in 2006. He was making progress towards his release and in October 2010 moved to North Sea Camp, a category D prison. The clinical reviewer noted that, on two occasions in 2011, he accidentally injured himself and this was not documented in his clinical record at the time
2. On 9 January 2012, the man absconded from North Sea Camp, but returned to the prison later that day. ACCT procedures were started as he said he had left the prison with the intention of killing himself. Due to his state of mind and security issues, he was immediately transferred to Lincoln. We understand the reasons for the decision but information given to the man and staff at Lincoln lacked clarity. Both seem to have been given the impression that he would return to North Sea Camp ten days later, which does not appear to have been the intention.
3. A full assessment of the man's risk of self-harm and suicide was not completed after he arrived at Lincoln. This took place only after he had made an attempt to end his life the following day. After a number of reviews, the man's ACCT monitoring was closed eight days later. We consider that this was premature as he was about to be transferred and some of the objectives identified to reduce his risk of suicide and self-harm had not yet been met. At the time, the post-closure review was set for 24 January.
4. Contrary to the man's and wing staff's expectations, he moved to Stafford on 20 January rather than returning to North Sea Camp. This had been arranged between governors and was not subject to the usual safeguards that would have applied had the transfer involved the offender management units. The man's ACCT documents were not transferred with him. Stafford quickly realised they were missing and contacted Lincoln who faxed the documents immediately and posted a hard copy the following Monday. Neither the faxed nor the hard copy were forwarded to the staff who needed them.
5. Although staff at Stafford were aware a post-closure review was due on 24 January, they did not complete it for reasons that are unclear. It is not possible to know whether, if this review had taken place, the ACCT would have been re-opened but it would have at least allowed further consideration of the man's risk.
6. The man's risk of suicide and self-harm was considered by a range of staff at Stafford and none believed he was a risk to himself, but they did not have the full information about him. He also appears to have hidden his feelings. Other prisoners told the investigator that, although he was upset at being transferred to Stafford, they believed he was looking toward the future and did not believe he was a risk of suicide or self-harm. It is clearly difficult to assess risk in such situations and we must be careful not to apply the benefit of hindsight. However, we agree with the clinical reviewer's conclusion that there was over reliance on what he said, rather than a clear consideration of the factors pertinent to his risk of suicide and self-harm.

7. The man's stepfather telephoned Stafford prison on 25 January after his partner had spoken to her son. He asked to speak to a number of members of staff, including any governor, and told the person on the switchboard that he was concerned about his stepson's welfare. The man's stepfather was told that his concerns must be put in writing and it was not possible to speak to anyone over the telephone. This was incorrect advice and he should have been put straight through to a duty governor.
8. When the man was found hanging, at 6.13am on a morning in January, staff acted quickly, calmly and competently. An ambulance arrived at the prison within five minutes but at 6.36am the paramedics confirmed he had died. They said this had probably occurred a number of hours earlier. Although it would not have made any difference to the care the man received, we note there is no emergency code system in place at Stafford, despite this being set out in the PCT's policy. This should be properly implemented at Stafford and prison staff briefed in its use.
9. The majority of staff said they had felt sufficiently supported following the man's death, although some were not told about his death before they arrived on the wing the following day. One prisoner, the man's closest friend, did not receive the support which he was promised.
10. Overall, staff at all three prisons where the man lived during his last three weeks of life made active attempts to engage with him and assess and reduce his risk of self-harm and suicide. It is a concern that these efforts were not better supported by the correct use of the ACCT framework or in a more proactive approach to dealing with the man's concerns.

THE INVESTIGATION PROCESS

11. The Ombudsman's office was notified of the man's death on 27 January 2012. The investigator visited Stafford on 7 February and collected documents relating to the man. She met the Governor and a senior officer who is a Prison Officers' Association representative. The investigator also met the vice chair of the Independent Monitoring Board (IMB). The man had not made any applications to the IMB.
12. The investigator issued notices inviting staff and prisoners to contact her with any relevant information. A number of prisoners came forward as a result and she interviewed them on 7 February.
13. South Staffordshire PCT commissioned a clinical reviewer to review the clinical care the man received in custody. The clinical reviewer and the investigator completed joint interviews with staff at Stafford on 13 and 14 March. The clinical reviewer completed her review on 8 May.
14. The investigator completed further interviews at Stafford on 13 and 14 March. In addition, she interviewed a number of staff at HMP Lincoln and HMP North Sea Camp by telephone, as well as the man's offender manager in the community. She gave the Governor of Stafford written feedback on the progress of the investigation in April.
15. On 14 March, the investigator had a meeting with a detective sergeant (DS). The investigator was given copies of the police witness statements and details of the man's telephone calls while he had been in prison. The detective sergeant had established there was no criminal issue involved in the case and the Ombudsman's investigation could proceed.
16. Her Majesty's Coroner for Staffordshire was notified of the investigation and will receive a copy of this report to assist with his enquiries. The post-mortem report concluded that the cause of the man's death was "suspension due to hanging".
17. One of the Ombudsman's family liaison officers contacted the man's mother on 15 February, to explain the purpose of the investigation and invite her to ask any questions or concerns about the care her son received in prison. She raised the following issues:
 - Why she was not informed of her son's death until 1.30pm when he had been found shortly after 6.00am?
 - Why was she informed by the police?
 - When and why staff had stopped her son's self-harm monitoring?
 - She had telephoned the prison on 25 January and asked to speak to a governor as she was concerned for her son's welfare. She was told she would have to put any request in writing any further assistance. Was this appropriate advice?
 - What were the circumstances surrounding her son cutting his wrists at HMP Lincoln?

- Why had her son lost his category D status and, possibly as a result of this, had to move to HMP Stafford?

The man's family made a number of points in response to the draft report. Where appropriate, the report has been amended to reflect their comments.

HMP STAFFORD

18. HMP Stafford is a category C training prison which holds up to 741 prisoners. The man lived on E wing which, together with F wing, form an area of the prison known as the Crescent. The Crescent is designated as accommodation for vulnerable prisoners (those who are separated from the majority of prisoners because of factors such as the type of offence they have committed).
19. Healthcare is provided by South Staffordshire Primary Care Trust (PCT). There is no inpatient healthcare facility at Stafford and no nursing presence in the prison overnight.

HM Inspectorate of Prisons

20. Stafford was last inspected by HM Inspectorate of Prisons in July 2011. The Chief Inspector concluded the following:

“In recent years we have noted improvements to the regime, the maintenance of reasonable environmental standards and the challenging of negative relationships and cultures. When we last visited in 2009 we reported that Stafford was performing reasonably well against all four of our healthy prison tests. It is commendable that at this full announced inspection we found that not only had these outcomes been maintained but that in one area, activity, the outcomes were now good ... the prison’s approach to self-harm issues was generally good, with an appropriate focus on the risks ...

“The self-harm and suicide prevention policy had recently been reviewed and was properly focused on the specific risks and needs of prisoners. It was generally well promoted and understood by staff and prisoners.”

Independent Monitoring Board (IMB)

21. In their annual report for the period ending April 2011, the IMB (a body of local unpaid volunteers appointed by the Secretary of State for Justice, who independently monitor and report on the prison) made the following comments regarding safer custody:

“The Board understands that there are an increasing number of prisoners arriving at HMP Stafford who had their assessment care in custody (ACCT) documents closed shortly before their transfer only to have them, of necessity, re-opened upon arrival; this predictably, has contributed to the prison’s number of ACCTs.”

Previous deaths at Stafford

22. This man was the tenth prisoner to die at Stafford since the Ombudsman began investigating deaths in prison in 2004. Two of these previous deaths were self-inflicted, the rest due to natural causes. There has also been one

further death due to natural causes since that of this man in which we recommended that an emergency code is introduced at Stafford. We repeat this recommendation in this report.

Categorisation

23. Prisoners are risk assessed when they go into prison and given a category based on their offence and the risk that they pose to the public should they escape. Category A prisoners are those whose escape would be highly dangerous. Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult. Category C prisoners are those who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape. Category D prisoners are those who can be reasonably trusted to serve their sentences in open conditions. There are no physical barriers preventing a prisoner from absconding if they wish to do so.

HMP North Sea Camp

24. HMP North Sea Camp is a category D prison in Lincolnshire. In certain circumstances a prisoner will be allowed to leave prison on a temporary licence either for compassionate reasons or to help the prisoner improve their chances of resettlement after their release. Category D prisoners may be assessed as suitable for release on temporary licence (ROTL) to work or allowed home leave. It holds up to 378 prisoners.

HMP Lincoln

25. HMP Lincoln is a category B local adult male prison. It receives prisoners remanded from courts across the East Midlands as well as serving prisoners transferred from other establishments. It has the capacity to hold a maximum of 738 men.

Multi-Agency Public Protection Arrangements (MAPPA)

26. Offenders who come within the Multi-Agency Public Protection Arrangements (MAPPA) remit are classified according to the type of offence, nature of the risk and its management. MAPPA members are convened, usually prior to a high risk prisoner's release, and comprise of local agencies, including the police, probation, social services, health, and / or other agencies, where appropriate, to assess and manage the risk they may pose on release.

27. There are three levels of MAPPA:

Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.

Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency,

very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.

Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.

Suicide and self-harm monitoring

28. The Assessment, Care in Custody and Teamwork (ACCT) system is the prison service-wide process for supporting and monitoring those prisoners thought to be 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.
29. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. As part of the process, a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings. Wherever possible, the prisoner at risk should be included in review meetings.

KEY EVENTS

Early period in custody, April 2006 – October 2010

30. The man was remanded to HMPYOI Lancaster Farms on 17 April 2006, charged with serious sexual offences. He was 18 years old. At the beginning of October, in the lead up to his trial, the man tied a bed sheet round his neck in an attempt to strangle himself. He was monitored under the prison suicide and self-harm procedures, Assessment Care in Custody and Teamwork, (ACCT).
31. On 29 November 2006, the man was convicted at a Crown court. He remained subject to ACCT procedures until 20 December 2006. The following month, on 29 January 2007, he was sentenced to an indeterminate sentence of imprisonment for public protection (IPP) at a Crown court. He was given a minimum period to three and a half years. This meant he could not be released until he had served the minimum term or tariff and the Parole Board assessed that his risk could be managed in the community. He would then remain subject to a licence for at least ten years and potentially for the rest of his life.
32. The man initially served his sentence in Lancaster Farms and Aylesbury young offender institutions. When he was 21, he transferred to an adult prison, HMP Stafford in April 2009, where he completed a number of programmes aimed at reducing his risk of offending. He worked as a cleaner on the wing and was described as an exemplary prisoner. He also completed literacy and numeracy qualifications, as well as a health and safety course.
33. The man had an oral hearing scheduled with the Parole Board on 28 April to decide whether he was suitable to be moved to a category D establishment or open prison. His offender manager (formerly probation officer) in the community, assisted in the preparation for this hearing. On 8 June 2010, the man received a letter to say that the Parole Board had decided that he was suitable to be moved to a category D establishment.

Move to North Sea Camp, 21 October 2010

34. On 21 October, the man transferred to HMP North Sea Camp, after an overnight stay at HMP Lincoln. He was appointed an offender supervisor in the prison with responsibility for liaising with him and his offender manager to assist the man's progression towards release.
35. The man became eligible for release on temporary licence (ROTL) in February 2011. This included day visits to the local town where he could meet friends and family and also a number of successive days of home leave.
36. Since he had been in prison, the man's mother had moved from the Manchester area to North Wales. The man also wanted to move to this area when released. His offender manager contacted Wales Probation Trust with the aim of transferring the case but the Welsh MAPPA wanted to complete

further risk assessments before accepting the man. In the meantime, his home leave had to take place in the Manchester area.

37. The man's offender manager made a referral to approved premises in Manchester since he had no home address in the area. The purpose of approved premises is to provide an enhanced level of residential supervision in the community, within a supportive and structured environment, for offenders assessed as presenting a high risk of harm.
38. On 20 April 2011, the man attended the local hospital after injuring his hand. This is not noted in the clinical record until 4 May when the prison received a follow up letter from the hospital.
39. Between April and September, the man was working at the Great Dane Sanctuary five days a week from 9.30am to 3.30pm. From 23 to 25 May, he was released to approved premises in Manchester and spent time with his mother and father while he was there.
40. From 18 to 21 July, the man was released to approved premises in Stockport. The Welsh MAPPA agreed that, if he complied with the conditions of his temporary release, the following visit in August could take place at Welsh approved premises with a view to transferring him permanently to their area.
41. During his temporary release in July, the man visited Wales. The Welsh MAPPA then refused to accept transfer of his case and wanted to meet again to discuss the risks he presented. There had been no conditions added to his temporary licence indicating he could not enter Wales and both his offender supervisor and offender manager assessed he had complied with the conditions of his licence. His offender manager said that, as a result of this setback, the man became disheartened with the process of transferring to Wales Probation Trust.
42. Greater Manchester Probation Trust had assessed the man as being a MAPPA level 1 case. However, Wales Probation Trust had categorised him as a level 2 case, enabling multi-agency management and meetings to occur. Wales Probation Trust was concerned about accepting him for a number of reasons. These included completing a risk assessment in relation to his partner's child; the local community had become aware of him and were opposed to him living in the area; and potential concerns about links to family members who had spent time in prison.
43. Another period of temporary release was approved on 26-30 September for the man to reside at approved premises in Manchester with licence conditions not to enter Wales or communicate with his partner. He breached these conditions and all his privileges were withdrawn. This meant he could not leave North Sea Camp for three months. His offender supervisor said the man was very upset about this, became stressed and did not eat as a result. He reported stomach pains and was taken to hospital with suspected appendicitis on 7 October and remained there until 12 October. It was discovered in hospital that he had a mobile telephone which had internet

access and was against prison rules. He was discharged back to the prison with a medical summary of abdominal pain, constipation and vomiting.

44. His offender manager said that the man's situation was very complex. He recognised that he became frustrated at not progressing as he would have hoped. However, his failure to comply with his release conditions and other prison rules had contributed to this.
45. In November 2011, the Parole Board did not agree to the man's release on licence. His offender supervisor said the man had been expecting this decision, remained positive and enrolled in educational and vocational courses. The revised plan was for him initially to be released to Manchester with a view to moving to Wales at a later date.
46. Following a referral by his offender supervisor, on 21 November, a mental health nurse assessed the man. They discussed his frustrations about the transfer of his supervision to Wales but he accepted that he would initially be released to the Manchester area. He told the nurse that a lot of his issues had been resolved, and he felt less stressed and more able to focus on the future. He and the nurse agreed he did not require the assistance of the prison mental health services at that time.
47. On 16 December, the man had an accident at work on the prison farm resulting in a puncture wound to his left hand. This was not documented on the clinical record until he returned from hospital the following day after treatment.
48. In January 2012, the man once again became eligible for home leave. He arranged to have a late Christmas celebration with his family at a caravan site near the prison on 7, 8 and 9 January, returning to the prison each evening. On 8 January, he had a disagreement with his mother and stepfather. Afterwards, he did not want to return to the prison but his stepfather insisted he did so.
49. On 9 January, the man attended the 7.30am count of prisoners and then left the prison by an unauthorised route. At around 10.30am, the man's mother arrived at the prison in some distress, with her partner. The deputy governor spoke to the man's mother who told her that her son had been found in the back of her partner's car at 8.30am that morning. The deputy governor and two members of staff escorted the man back to the prison. He later told staff that he had intended to commit suicide. It was decided to send him back to closed conditions as he posed a security risk in his current state of mind. The deputy governor's report noted:

“[The man] was a clear danger to himself and he was not thinking rationally and in a very distressed state ... His problems related to family matters.”

She added that this was never intended to be a “closed door scenario” preventing him from returning to North Sea Camp.

50. The deputy governor told the investigator that due to the risk the man presented to himself and the potential risk of absconding, it was no longer appropriate for him to remain in a category D prison so a transfer to HMP Lincoln was arranged. She explained that he would have had a period of one month to appeal his return to closed conditions. He was not recategorised and remained a category D prisoner. The deputy governor thought that once the man had stabilised he might be considered for transfer to HMP Wymott since this was nearer to the Manchester area. She said that the decision as to whether the man would return to North Sea Camp or another category D establishment would be made in conjunction with the Parole Board and his offender supervisor or manager.
51. The man's mother told the investigator that the deputy governor said that she had done the best thing for her son in notifying the prison where he was and that he would be safe from now on. His mother had asked the duty governor if he could have an urgent psychiatric assessment and she replied that she would forward the request to Lincoln.
52. A senior officer completed a concern and keep safe form (the first stage of the ACCT plan) at North Sea Camp at 12.15pm. The concerns were that the man had said he wanted to kill himself and was in a very low mood. The form notes:
- “[The man] is at a low point in his life. He is an IPP prisoner who feels very let down by the system, he sees no short term improvement and says he feels like ending his life. He feels he is a drain on his family and that he is a burden to them.”
- The immediate action plan, completed at 12.45pm, noted, “Transfer to HMP Lincoln, remain cat D, full assessment review required on reception”.
53. A Person Escort Record (PER) accompanies each person when they move between police station, court and prison. It contains information about the individual's needs and the risk he poses to himself and others. The man's PER indicated that ACCT measures had been put in place on 9 January and that the associated document was with the man. He left the prison at 1.45pm.

HMP Lincoln, 9 January 2012 – 20 January 2012

54. The man arrived at Lincoln at 3.35pm. His initial healthscreen was recorded at 6.46pm. It was noted that he was calm with good eye contact and body language and that he was, “feeling low in mood at present but no thoughts of suicide and self-harm”. The record also noted he was subject to ACCT procedures and that staff should observe him hourly with three conversations daily as part of the ACCT monitoring.
55. After her son's death, his mother told the police that she had received a telephone call from a governor at North Sea Camp on 9 January explaining

that her son had been transferred to Lincoln for ten days while he was assessed further.

56. On 10 January, at around 2.00pm, a senior officer was unlocking prisoners for induction. After she had unlocked the man's cell, he asked to see a nurse and showed the SO two deep cuts he had made to his left wrist. The SO requested a nurse's assistance and the man told her that he wanted to be dead and that "if he had the balls he would be dead now". He told the SO he had written two suicide notes.
57. A nurse treated the wound. The man told him he had had enough and "wanted to end it". The nurse informed the mental health team. Meanwhile, officers constantly supervised him. A mental health nurse assessed him at 2.40pm that afternoon. He told the nurse that he was having difficulty seeing a future and felt a burden to his family. He said he might self-harm again.
58. Following this interview, a senior officer intended to complete the ACCT assessment with the man. However, his wounds re-opened and he attended hospital for stitches so the assessment was postponed. The man left the prison at 4.20pm and returned at 7.00pm.
59. The man's ACCT assessment interview took place with a senior officer immediately he returned from the hospital. He said he had problems with probation and was confused as to why he had moved to Lincoln. In relation to cutting his wrist, the assessment noted, "he feels like he has had all the fight and life drained from him". He told the SO that he had needed an outlet but now felt he had the support he needed from staff and the mental health team. The ACCT assessment recorded that he had transferred to Lincoln temporarily for ten days.
60. A further SO completed the action following assessment section of the ACCT form at 7.05pm. The SO recorded that he had accompanied the man to the hospital where they had discussed the reasons he had harmed himself and wanted to die. They continued this conversation along with the senior officer who had conducted the man's ACCT assessment. He told the SOs that talking over the past couple of hours had made him realise "that he has to get through all this for the sake of his family". The SO assessed the man's risk as raised but concluded that there was no longer an immediate risk of suicide. He reduce the man's observations to twice an hour.
61. Staff recorded in the CAREMAP that they had reassured the man he would return to North Sea Camp and the deputy governor at North Sea Camp would look into the problem with probation and his release address. He was given the opportunity to telephone his family on 10 January. He was also to receive support from mental health staff about distraction techniques in relation to suicide and self-harm and a nurse would refer him to mental health staff at North Sea Camp for mental health input. He moved into a cell with a prisoner he knew, rather than sharing a cell with a prisoner receiving treatment for drug dependency.

62. The man was initially located on A wing. A Principal Officer (PO) worked on that wing and was also manager of the safer custody department. Although she did not have any direct contact with him, she understood from staff on the wing that he was distraught that he had been transferred to Lincoln. The PO said that the man was assured it was a temporary arrangement while North Sea Camp conducted an investigation.
63. On 11 January, the second ACCT case review took place at 2.20pm. The same senior officer from the first ACCT case review and a nurse were present, along with the man. The senior officer noted that the man was “much more upbeat” and “ready to fight for his future”. His risk was assessed as low and observations were reduced to hourly. The review refers to the man returning to North Sea Camp on 19 January.
64. At 5.45pm, the man telephoned his mother’s home and told his stepfather that he had cut his wrists the night before. His stepfather told him that a governor at North Sea Camp had said that he was on a “lie down period” to sort himself out.
65. The following day, his offender supervisor visited the man who asked her if he could return to North Sea Camp. The offender supervisor said that he should accept mental health input and asked why he had harmed himself. He told her that he had been unable to cope with the slamming doors, his cell mate detoxifying and “his head just went”.
66. The man’s offender supervisor told the investigator that he would pretend that he was coping even when he was not. She explained that it was not her decision whether he returned to North Sea Camp. Her role was to write a report and speak to the deputy governor who could rescind the man’s suitability for category D conditions. However, his case would be considered by the Parole Board, as he was an IPP prisoner, and he would have an opportunity to make representations to them. It is unclear whether she communicated this to the man. The offender supervisor completed her report and consulted the deputy governor at North Sea Camp. They considered that he was no longer suitable to be in an open prison and the report was sent to the Public Protection Casework Section (PPCS) for them to make the final decision about recategorisation.
67. The man wrote to the deputy governor on 11 January thanking her for the way she had dealt with him on 9 January. He said that he now realised he must concentrate on himself and not feel guilty about the effect he had on his family. He added that if he had to stay in closed conditions he would work towards open conditions once more and demonstrate his compliance. (The deputy governor replied to this letter on 23 January encouraging the man to apply to return to North Sea Camp if he was assessed as suitable by the Parole Board and his offender manager. He did not receive this letter before he died.)

68. At 5.55pm that evening, the man called his partner. They discussed what had happened at the weekend and their future. He told her he had “tried to end it”. His partner said that she would support him.
69. On 13 January, the third ACCT case review was held. It was recorded that staff at North Sea Camp were willing for the man to return there on 19 January. The man said he had no thoughts of self-harm. A mental health nurse was present and noted he had “good engagement and insight into current crisis”. The man said he would consider why he had tried to commit suicide. His risk level remained assessed as low and required observations were reduced to twice daily. The nurse noted that the mental health team at North Sea Camp should follow him up if he returned there. The summary of this review concludes “book to be closed at next review”.
70. On 16 January a mental health nurse assessed the man. He said he was frustrated with the prison system and that this had led to him cutting his wrist. The man said the plan was for him to move back to North Sea Camp in three days and engage with the mental health team there.
71. A senior officer led the ACCT case review on 17 January. Also present were the man, a prison officer and a nurse. The senior officer recalled the review was “upbeat”. He said the man had good eye contact, positive body language and answered questions immediately. They discussed how he had felt when he harmed himself on 9 January, to which he said he had been in a “dark place” but was no more specific than this. He told staff that he felt a lot better and needed to be strong for his family. He wanted to return to North Sea Camp and the senior officer had been under the impression this was likely although no date for his return had been set. His risk was assessed as low.
72. The senior officer also recorded on the ACCT document, “A lot depends on him moving back to North Sea Camp as planned but if that does not happen we will re-evaluate”. He told the investigator that this re-evaluation would have taken place at the post-closure review. The SO said that all those present agreed that the ACCT procedures should be stopped and the post-closure review was set for seven days later. The SO told the man to speak to staff on the wing if he had any concerns in the meantime. The SO had been under the impression that if the man’s ACCT was closed and his mental health assessed as suitable, he would return to North Sea Camp.
73. There is also a note in the medical record made by a nurse that “[the man] hopes to move back but is aware things may change and he will then have to deal with it if and when they happen but is realistic about the transfer back to HMP NSC.”
74. The duty governor at North Sea Camp on 18 January said that, as the man had been sentenced to IPP, Lincoln wanted to move him on. (Prisoners do not generally stay at local prisons for long periods.) Due to the potential risks of absconding and self-harm and suicide, North Sea Camp would not accept him back at that time. The duty governor explained that in such situations the

policy is to return the prisoner to the adult establishment where they began their sentence. In this man's case, this was Stafford.

75. The duty governor said that the man would remain a category D prisoner and a decision would be taken within 28 days as to whether he would be recategorised or return to North Sea Camp. He telephoned the duty governor at Stafford on 18 January and explained that he wished to transfer the man there. The duty governor at Stafford was also head of residence at the time. He was not often involved in the transfers of prisoners which would normally be facilitated between the offender management units (OMU) in both prisons. The duty governor told the investigator that the duty governor at Stafford had asked whether the man was subject to ACCT monitoring and he told him that it had ended.
76. The duty governor at Stafford could not recall asking about the ACCT arrangements. He told the investigator that regardless of whether the man was subject to ACCT monitoring he would have had to move from Lincoln as it was a local prison and could not offer the same range of facilities as Stafford. He was not aware that the ACCT had been closed the day before and that he would have alerted staff at Stafford to this had he known. The duty governor at North Sea Camp contacted the population management unit (PMU) that afternoon to arrange the man's transfer to Stafford.
77. The duty governor at Stafford emailed a number of governors at Stafford to tell them that the man had failed in open conditions and would be returning to Stafford. He was not on duty the following day but when he was back in the prison on 20 January there were no messages for him.
78. The duty governor at Lincoln on 18 January received a call from the duty governor at North Sea Camp to inform her that the man was moving to Stafford. As the duty governor at Lincoln had no previous involvement with the man, she asked the duty governor at North Sea Camp to confirm this in writing which he did at 1.15pm, also copying in the duty governor at Stafford. The duty governor at Lincoln informed an administrative officer in the movements department at Lincoln. She also forwarded the duty governor's email to her at 4.00pm, copying in the Deputy Governor, as well as Head of Operations and Head of Security and deputy head of operations and security.
79. On 19 January, just after 2.00pm, the administrative officer emailed the managers above to indicate that she had received confirmation that the man would move to Stafford the following day. She told the investigator that she did this at the request of an officer who normally processed all IPP prisoner transfers. She had assumed that the officer had already checked whether the man was subject to ACCT monitoring. She was not aware that he was in the post-closure stage of the process. She said if she had been aware, she would have included the safer custody department in this email. The member of staff who was duty governor on 18 January forwarded this information to the duty governor on duty and to the member of staff who would be duty governor the following day. The Safer custody team was not informed of the man's imminent transfer. A principal officer, who was also the safer custody

manager, said that at this point she and staff on the wing all still believed the man was to transfer back to North Sea Camp.

80. At 1.10pm, on 19 January, an officer completed the first section of the PER indicating that the previous ACCT had been closed on 17 January. The tick box to indicate whether the ACCT document was attached was left blank. A second person (whose name is illegible) completed the health risks section of the form at 2.00am (on 20 January) and noted wounds from self-harm on his left wrist. On the second page of the PER, it was not indicated in the section provided that the man had been subject to a recent ACCT.
81. On 20 January, the duty governor at North Sea Camp telephoned the duty governor at Lincoln who confirmed that the ACCT monitoring procedures remained closed. The duty governor at North Sea Camp arranged for the man to transfer to Stafford in the usual way in an escort van with a number of prisoners. Had the man remained subject to ACCT procedures, the duty governor at North Sea Camp said he would have considered alternative transport such as a taxi with escorting officers. The man left Lincoln at 10.10am. His ACCT documents were not sent with him.
82. Having viewed the draft report, the man's family told the investigator that during this transfer he was handcuffed. A decision regarding the level of restraint should take place after completion of a risk assessment in relation to the prisoner's risk of escape and harm to others. The investigator was not given evidence of such a risk assessment having taken place.

HMP Stafford 20 January 2012 – date of man's death

20 January

83. An officer who works in Stafford's OMU had been checking the movements sheet when she became aware that the man was already on his way to Stafford prison. She telephoned the safer custody department at Lincoln and spoke to an administrative officer. The administrative officer contacted the duty governor who telephoned Stafford and they agreed to accept the man.
84. The officer who works in Stafford's OMU said that she normally received a prisoner's ACCT document before a transfer, if they are within the post-closure period of monitoring. She would send this to Stafford's safer custody department to assess whether the transfer is appropriate and would also forward the documents to reception and the wing. Any transfer is processed via the Population Management Unit (PMU) at NOMS HQ who agree that a transfer can take place. It is Stafford OMU's responsibility to alert the prisoner and prison concerned and they would request documentation before the prisoner's arrival.
85. A senior officer was in reception when the man arrived at 2.50pm. She noticed that, although ACCT documents were referred to on the PER, they had not been sent with him. She explained that ordinarily she would not expect to know the names of prisoners arriving at Stafford. PMU would

advise how many prisoners they would be receiving that day and from where. She had no prior knowledge that the man or anyone from Lincoln was due to arrive.

86. The senior officer rang E Wing at Lincoln (where the man had been) to request the ACCT document. She was referred to an administrative officer. The administrative officer explained the document had not been sent as she was unaware of the transfer until he had already left the prison. She apologised and offered to fax the document to Stafford immediately. She marked it urgent for the SO on E wing (the induction wing where the man would be located) and also posted a hard copy by recorded delivery on Monday 23 January). She told the senior officer when the ACCT had been closed and the date the post-closure review was due.
87. The senior officer then contacted the duty governor at Stafford to explain the ACCT documents were missing, although they had been closed and she would assess the man herself. She also informed a senior officer on E wing that the man would shortly be coming to them, the date his ACCT document had been closed and the date the post-closure review was due. The SO then asked the man if he had any concerns about being at Stafford. He said no. The senior officer did not ask him directly about his ACCT or thoughts of suicide or self-harm as she thought he would have volunteered this information rather than saying he was "fine". The SO said the man seemed "calm and relaxed". She then also asked a nurse to assess him as he had recently been subject to ACCT procedures.
88. An administration assistant at Stafford picked up the faxed ACCT when it arrived at 3.30pm and noted it was urgently marked for the SO on E wing. She telephoned the wing, who told her that the fax was not for them but might be for the OMU. The administration assistant was unsure who she spoke to and none of the staff interviewed recalled the conversation.
89. The administration assistant then telephoned OMU to check if they wanted to collect the fax or if she should put it in their in-tray in the staff information room. She believed she spoke to an officer, who confirmed it was appropriate for her to put it in the tray. She was unsure whether she had told OMU that it was an ACCT document for the man but had told them it was marked urgent for an SO on E wing.
90. The investigator spoke to the officer. He could not remember having this conversation with the administration assistant. He said he would have asked for more information before indicating the fax could be put in the OMU tray.
91. The OMU office manager said that the OMU tray is emptied twice daily. Any faxes in connection with an IPP prisoner are put in an administration officer's tray. The administration officer remembered putting the fax in the man's file. She believed that it had been forwarded from E wing and was for information purposes only. She was aware that it was an ACCT document.

92. A nurse completed the man's reception healthscreen. The nurse had received a brief summary of the man's clinical care before meeting him but did not otherwise review his clinical record. When a prisoner is transferred, the sending establishment has to forward the clinical record electronically so that the receiving prison can access it. The nurse was unsure whether this had been done before the man arrived at Stafford. He told the investigator that sometimes he has an opportunity to review health records before meeting a prisoner but did not on this occasion. A further nurse was also present during the assessment.
93. The nurse who completed the man's healthscreen was aware of his recent ACCT monitoring although he could not remember whether he saw this in the clinical summary or if the man had told him. They discussed his recent self-harm and judged that this had been a reaction to being moved from a category D prison. They also discussed his previous self-harm in 2005. The man denied any current thoughts of suicide or self-harm. From talking to the man, he assessed that he was no longer a risk of suicide or self-harm. Although upset at being moved from a category D establishment, the nurse thought the man seemed happy to be at Stafford, in the circumstances, as he had been there before and knew the prison and some of the staff. However, he told the investigator that the man seemed slightly agitated, that issues about his management remained unresolved and he was anxious as he had not yet contacted his family about his transfer.
94. The nurse summarised his assessment in the clinical record by recording, "he cut his left wrist recently, attempted to end life, not wanting to end life, too much to lose, no referrals made". The nurse explained that despite this assessment, he still completed a Threshold Assessment Grid (TAG) assessment due to concerns he had regarding the man's recent self-harm and agitation about what he believed to be losing his category D status. The TAG is the tool used to assess a prisoner's risk of suicide and self-harm and refer them to primary mental health services and determines the priority with which they will be given an appointment. The TAG score was 2.
95. The nurse explained that as the TAG score was relatively low, the man's case would not be considered a priority. (The maximum score is 24.) He printed off the TAG and placed it in the tray for the mental health team, as was the process with all referrals. The team would then discuss all referrals at a meeting and prioritise them. From talking to the man and the medical overview with which he had been provided, the nurse was aware that an ACCT post-closure review had not been completed but told the investigator this was not his responsibility. He also booked him an appointment with the doctor to review the injury to his hand which had occurred months earlier. Following the assessment, a senior officer telephoned her colleague and fellow SO and told him that the nurses did not think ACCT measures needed to be re-opened.
96. When the man arrived on E wing at around 4.15pm, the senior officer invited him into the wing office and asked him how he was feeling. He said the man said he was fine but did not understand why he was at Stafford. He had no

feelings of suicide or self-harm and discussed his recently closed ACCT. The SO explained that as he had very limited information, he decided to put him in a double cell. The man agreed to this and said he would not want to be on his own for very long anyway. This statement in itself caused the SO some concern.

97. The senior officer told the investigator the man was talkative and seemed confident. He didn't seem down or in any sort of despair, neither did he ask for any help. The SO said the man's tone of voice, body language and posture all seemed appropriate and he took this into consideration in assessing his mood.
98. A prison officer was allocated as the man's personal officer. (This is a named officer to whom a prisoner can go for advice or to resolve complaints and who should actively engage with their prisoners and get to know them.) The senior officer on E wing explained what he knew about the man to her and said he would be getting a cell mate soon. He recorded the conversation he had with the man in the observation book as follows:

"staff pls be aware of him recently coming off an ACCT and converse with him when possible to ascertain his moods and feelings".
99. The senior officer also indicated a post-closure review was due and on the man's case record that his ACCT had been closed on 18 January (which was inaccurate by one day). He said he would expect staff to read the observation book and that the wing SO should ensure that staff were aware of the information in it.
100. An officer on the wing completed the man's reception interview, during which he said he had no thoughts of suicide or self-harm but wanted to know why he was at Stafford. He was told a governor would tell him the following week.
101. A prisoner who had also arrived at Stafford that day was later placed in the man's cell. The prisoner had known the man during his previous time at the prison and described him as someone who got on well with everyone. He said that he was surprised when the man returned to Stafford and he seemed frustrated at the lack of documentation explaining why he was there.
102. Another prisoner had also been friends with the man when he was at Stafford on the previous occasion. When he returned to Stafford, he was a Listener on the induction wing. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) The man told him that he had been having issues with probation and started to have a breakdown at North Sea Camp. He said he was then taken to Lincoln for 7-10 days to "get his head together". He believed his probation officer then decided he was not suitable for open conditions and he was brought back to Stafford. He said the man had a different attitude when he returned to Stafford in that he was more negative, had given up and thought he would never be released. However, he did not think he was a risk of suicide or self-harm.

21 January

103. Although SOs can be rotated around the prison, they are mainly allocated to one particular wing. Two SOs worked on E wing at the time. One of them was on annual leave for the whole of the time that the man was at Stafford on the second occasion.
104. The remaining SO was on duty on 21 January. He cannot specifically recall seeing the man that day but as wing manager knew that he had arrived the day before. He read the observation book at the start of his shift and was aware that the man's ACCT had recently been closed and a post-closure review was due. He said it would be his responsibility to ensure the review was completed. However, he told the investigator he could not do so as he did not know when it was due.
105. An officer completed the second day interview with the man. The aim of this was to find out how he felt after his first night in prison, check that he had information about the Samaritans and Listener scheme and ensure he contacted anyone he needed to. The man told the officer he had recently been subject to ACCT monitoring but denied any thoughts of suicide or self-harm.
106. The officer said that the man seemed annoyed and frustrated at being back at Stafford and wanted more information about why he had returned there. He said the man seemed honest and willing to engage with the prison and told the officer he had booked to start a gym course on Monday. He believed the man was trying to make progress in his sentence and did not consider there was any risk of suicide or self-harm. He asked to see a governor, but as it was the weekend the officer told him this would have to wait until Monday. He left a voicemail message for the duty governor at Stafford asking him to speak to the man on his return to the prison.

23 January

107. The man was due to see the doctor on 23 January about his hand injury but, due to time constraints, this appointment was rebooked for 26 January. He telephoned his mother at 9.07am. He spoke to her about the move to Stafford. He told her that he was unaware of the transfer to Stafford until 6.00am on the morning of 20 January when officers came to get him from his cell. Then he spoke to his stepfather and made a comment that he could not do it anymore and it was "game over". He asked his stepfather to look after his mother.
108. Around 9.15am that morning two prisoners overheard the man becoming agitated on the telephone. He slammed the telephone down, kicked a bin and told them he was upset with his probation officer. Presumably, this was after the conversation with his family since no other telephone numbers are recorded on his pinphone record.

109. That morning, the duty governor spoke to the man. An officer was present for much of the meeting. The man wanted to know whether he had been recategorised and why he was back at Stafford. He had expected to go to Lincoln for a few days and then return to North Sea Camp. They also discussed his recent self-harm. The duty governor did not think that the man presented a current risk of suicide or self-harm. He said he regretted cutting himself and was now looking to the future. The duty governor explained the reasons that he was aware of for the man's transfer and said he would not have to wait long to know more. He also told the man that he believed he should have a recategorisation form in his file.
110. The man said he felt that returning to a category C prison was a step back and he had let everyone down. He asked if he would be able to return to his old wing. Despite this, the duty governor felt the man had left the meeting in a positive frame of mind looking toward the future. He concluded that the self-harm had occurred in a moment of crisis which had now passed. After the meeting, he asked the officer to check the man's file for recategorisation documents. The officer could not find any and, when he returned to the wing, he informed the man of this.
111. His offender manager had a telephone call that day from the man's mother and partner who were angry that the man was not going to be transferred to Wales Probation Trust. The offender manager explained that the man could not progress towards release until he demonstrated he could comply with ROTL conditions. He said that the man knew he would have to be released to Manchester approved premises initially before, as he hoped, transferring to Wales Probation Trust. He said that the man's mother and partner did not raise any concerns about his risk of suicide or self-harm. He said if they had done so, he would have telephoned the man's offender supervisor at HMP Stafford immediately to inform them of this risk. He had no further contact with the man or his family. His mother said that she had rung him on 24 January as she could not get through to the prison as she was worried about her son's welfare. The offender manager denied this and it is not documented in his record of contact.
112. That afternoon, the chaplain spoke to the man as part of his induction. He gave her no cause for concern and said he would be getting visits from his family.
113. Between 6.00pm and 7.00pm that evening, the man telephoned his mother and spoke to her for around forty minutes (in four separate conversations). She explained that his offender manager had told her that her son knew why he had been moved from open conditions. They discussed his categorisation and that he had not known that he was going to be moved to Stafford until 6.00am on the morning of his transfer when he was taken from his cell.
114. The man told his mother that he knew he might be recategorised but had not managed to "get an answer" from anyone and just wanted to find out a decision either way. He said he had not got the strength to do more years in prison and when his mother asked if he wanted to end his life, he replied that

he did not know anymore. He said that his sentence seemed endless but at least if he knew what he was facing he would know what he needed to do.

24 January

115. His cell mate said that around 24 January, the man told him that he had said to officers he would kill himself if they did not tell him why he was back at Stafford. His cell mate did not believe he was serious and that he would have approached staff or other prisoners if he had believed the man was at risk.
116. There is a safer custody co-ordinator at Stafford with responsibility for overseeing ACCT monitoring and answering any staff queries. The posted copy of the ACCT documents was received by Stafford post room on 24 January. The safer custody co-ordinator believes he was contacted by the post room on 26 January (he was not in the prison on 25 January) to inform him the document was there. Staff in the post room do not record when a document is collected but believed they had contacted the SO on 24 January. Such conversations are not recorded, so it is impossible to determine when this occurred. The safer custody co-ordinator said that he had been very busy in different locations on 24 January so it might not have been possible to contact him as he did not have a voicemail.

25 January

117. Another prisoner had known the man during his previous time at Stafford. He was surprised to see the man return to Stafford and, on the day he arrived, he told him he had been having problems with probation and had lost his category D status. On 25 January, he spoke to the man for around 20 minutes. The man related the problems about his transfer to Wales Probation Trust. He said he felt like killing himself as he thought he would have to start all over again, could not face another four years in prison and had no fight left in him. The fellow prisoner said he told him "I'm broken". The man told him that the Governor at North Sea Camp had said he would not lose his category D status but he needed to move to another prison for ten days temporarily to "cool off". In spite of what he was told, his fellow prisoner said he did not think the man would kill himself.
118. Another friend from previously said that the man told him that he had spoken to prison staff to try and find out if he was returning to North Sea Camp. His friend said the man had told him that he had said to an SO "the way things are going you will have a suicide on your hands". He told his friend that staff had discussed opening an ACCT with him but decided this was not necessary. The investigator asked an SO about such a conversation since he had been the main SO on duty during that week. The SO denied having any conversation with the man regarding thoughts of suicide.
119. As the man's mother was so distressed and concerned by the calls that her son had made to her, she asked her partner to telephone the prison on 25 January. The man's stepfather did so and asked to speak to two different SOs or a governor as he was concerned for his stepson's welfare, specifically

naming his step-son. He was told he would have to put his request and concerns in writing and was not offered any help or advice

26 January

120. The safer custody co-ordinator believes he picked up the ACCT which had been posted from Lincoln on the morning of 26 January. Although he does not specifically remember opening it, he believes he would have noticed it was a closed ACCT document and would not have thought it was a priority document. The SO thinks he placed it on his desk to be processed later as he was delivering training that afternoon.
121. At around 10.00am that morning, another prisoner spoke to the man for around an hour. The man again spoke about the difficulties in transferring his case to Wales and his concerns about his partner and mother, now that he had returned to Stafford. However, his fellow prisoner thought that despite these worries, he seemed positive and was looking to the future. He said the man was concerned that he had been returned to Stafford and had no documents confirming why. He did not believe he was at risk of self-harm or suicide.
122. At 10.30am, his cell-mate moved wings, as he had completed his induction, leaving the man on his own in his cell. He said that the man seemed fine at this point. Later that morning, he had an appointment with a doctor for irritable bowel syndrome. The doctor also referred him for physiotherapy following his hand injury and to see a mental health nurse. The doctor told the clinical reviewer this was because:
- “I had been asked to see [the man] as he was a new reception and that he was not happy with being transferred from a Cat D prison to a Cat C and felt he shouldn't have been transferred to Stafford. He also complained of poor sleep. He did not express any thoughts of self harm. Due to the difficult circumstances he was going through I felt he would benefit from being assessed fully and supported by an RMN. Usually an RMN would spend more time completing an assessment following which he could be referred back to a GP if needed or managed with psychological therapy.”
123. A nurse had also been present during the man's assessment with the doctor. Afterwards, she completed a TAG. The nurse said he was calm, maintained eye contact and was friendly towards her as he recognised her from his previous time in Stafford. She said he seemed relaxed and insightful and she was not concerned in relation to any risk of suicide or self-harm. The nurse recorded “No active thought to self-harm at present but is struggling daily; feels he's having a breakdown.” He scored 5 which the nurse believed meant he would be considered a non-urgent referral and would be seen by a mental health nurse within 28 days. The nurse printed off the TAG and put it in the mental health tray. They were due to have their weekly allocation meeting that afternoon but it did not take place as scheduled. However, the mental health nurses would pick up referrals in the meantime.

124. The nurse had calculated from what the man had disclosed to her that a post-closure review was due. She recorded this in the clinical record for information and assumed it would be carried out by staff on the wing, since it was their responsibility. She had not read his clinical record, nor was she aware that a TAG had been completed by a nurse on the day he arrived at Stafford. She explained to the man what she had recorded and the referral process.
125. An SO recalled seeing the man outside his wing office on the morning of 26 January. While on the landing, he asked him how he was and the man's main concern was finding out whether he had been recategorised from a category D to a category C prisoner. The SO said that no documents had accompanied him confirming this either way. He did not assess the man to be at risk of self-harm or suicide and told the investigator he seemed "calm and collected".
126. An officer spoke to the man that morning and said that he had completed his induction so he was waiting for a space to become free on F wing to move him, as he had previously lived there and knew the staff. The officer said the man seemed very accepting of this.
127. That day, the man asked a fellow prisoner if he could borrow some of his computer games. He said the man seemed content and nothing concerned him about their conversation. He added that three other prisoners had heard him go to the wing office and tell the SO that he was angry and, if nothing happened, they would have consequences on their hands. This information could not be corroborated.
128. At 4.16pm, a case manager at PPCS at NOMS HQ sent an email to an administration officer with a copy of a letter that had been sent to the man. The administration officer forwarded this email the following morning at 8.06am (when she first read it) to the duty governor and an officer from Stafford's OMU. The letter stated that PPCS would need to consider the man's suitability for open conditions in light of him absconding from North Sea Camp, his distressed state of mind and threats to take his own life. This might involve a referral to the Parole Board and the man was invited to make any representations to a senior official at PPCS by 23 February.
129. Between 6.30pm and 7.00pm, just before they were locked in their cells, the man asked a fellow prisoner for an Argos catalogue and some sugar. His friend said they spoke for a couple of minutes and the man seemed fine.
130. Another fellow prisoner was playing cards with the man that evening on the landing. The man went to get his tobacco from the drawer in his cell and returned saying someone had stolen it. His friend said the man was upset by this and held his head in his hands. At 7.45pm they stopped playing cards and said they would see each other tomorrow.
131. An officer support grade (OSG) started work at 8.30pm that night. As the night OSG, she was locked on the wing and carried a sealed pouch with cell

keys in it to be used in the event of emergencies. She also had a radio. She received a handover (during which the man was not mentioned) and read the wing documents, then started checking cells and counting prisoners. This involved ensuring each cell door was secured and that the prisoner was inside. She was not expected to get a response from a prisoner and could not remember whether she spoke to the man or not.

The morning of the man's death

132. The OSG completed pegging checks every thirty minutes throughout the night. (Pegging is a form of patrol in which an electronic device is used to scan certain points in each unit, providing an auditable register of the patrol.) Shortly after 6.00am, she began counting the prisoners again. When she got to the man's cell, the OSG looked through the observation panel and realised that he was hanging from the window bars, tied with bedding around his neck.
133. Shocked by what she had seen, the OSG radioed the control room and said "emergency" and when asked for more details said "ligature". It was 6.13am. She asked for the night orderly officer, who had overall responsibility for the prison, to come as soon as possible and then asked permission to enter the cell. She received no reply and started to get her sealed pouch out. A principal officer (PO) explained that the policy is that once an OSG has announced the emergency, the radio would be switched to an open network and the orderly officer should give permission to enter the cell as they are arriving on the wing.
134. An officer overheard the request for emergency assistance. The orderly officer, assistant orderly officer and an officer were nearby and also heard the request. All four immediately went to the man's cell.
135. Before the OSG could get her sealed pouch open (she estimates within a minute of discovering the man), the SO and three officers had arrived at the cell. The SO looked through the observation hatch and immediately unlocked the cell. An officer lifted the man while a further officer cut the bedding from the window bars. The officer said that as he picked him up, he believed he exhaled and said "he's breathing". He took the man outside the cell where there was more room and placed him on the floor. At this point, his assessment of the man's condition changed as his body was stiff and his legs remained crossed when he was placed on the floor. The officer later explained that he might have gained the impression that the man was breathing due to the way he had picked him up and put pressure on his chest. He cut the bed linen from the man's neck and observed that he looked blue in colour.
136. The OSG and assistant orderly officer remained outside the cell and the SO asked for an ambulance to be called. The OSG immediately requested one via the control room at 6.15am. The SO started chest compressions as part of cardiopulmonary resuscitation (CPR) but noted that he was very stiff and it was difficult to do. Staff in the control room confirmed that an ambulance was on its way so one of the officers went to the gate to escort it in. The SO and

his colleague agreed that they could not save the man. They stopped CPR and carried him back into the cell.

137. Paramedics had arrived by the time the officer got to the gate at 6.18am and he escorted them in. They attached their electrocardiogram (ECG), to measure the electrical activity of the man's heart and confirmed his death at 6.36am. They said that they believed he had been dead for around six hours. The SO observed what looked like a suicide note which he left in the cell for police officers to examine. On the back of a photograph of the man's partner was a request to be buried in Wales and not to be forgotten, and a declaration of love to his partner.
138. Prison staff immediately contacted the duty governor and the deputy governor following confirmation of the man's death. The Governor could not be contacted until 8.00am. They immediately went to the prison. The man's mother told the investigator that she had telephoned the prison that morning at 9.30am to try and book a visit to see her son. This was due to her concerns for his welfare and the lack of assistance offered by the prison when her partner had telephoned them on the 25 January. She was not told of his death.
139. At 10.00am, the Governor considered how best to contact the man's mother, as she was unsure whether she would be in North Wales, the Manchester area or a caravan site. The deputy governor tried to contact the man's mother by telephone but there was no response. His mother told the investigator that she received no calls on her mobile telephone that morning. Greater Manchester Probation Trust then informed the prison that his mother might be vulnerable and so the prison was keen to deliver the news in person.
140. As they were unsure where the man's mother would be and they did not want to waste time, the Governor contacted Stafford Police. She asked them to contact North Wales Police to go to the man's mother's home to deliver the news. There was some delay in despatching an officer. On his way to her home the police officer was diverted to an emergency, so there was a further delay.
141. The police officer eventually arrived at 1.00pm and told the man's stepfather the news as there was no one else at home. His stepfather then telephoned the man's mother and told her over the telephone. The deputy governor, who was appointed as the prison's family liaison officer, then telephoned the man's mother and offered to go to North Wales to visit her but they preferred to meet at the prison.
142. The man's mother, stepfather, father and stepmother went to the prison and met the Governor, the family liaison officer and the chaplain. The man's stepfather said he had rung the prison a couple of days earlier and asked to speak to various members of staff but had not explained he was worried about his stepson's welfare. The family liaison officer remained in touch with the man's mother. The prison offered financial assistance with the cost of the funeral and his personal possessions were returned.

143. Staff debriefs were held immediately after the man's death and on 13 March. Most staff said they had felt well supported, although two officers said they had not been told about the man's death until they arrived on the wing the following morning and did not see any of the senior management team until that afternoon. They said they felt "isolated" and, in retrospect, one member of staff said he was unsure whether he was emotionally fit to be working at the time.
144. The SO on E wing reviewed prisoners subject to ACCT monitoring during the morning of the man's death. A notice to prisoners about the man's death was issued later that day offering the support of the Samaritans, Listeners and the chaplaincy.
145. The man's friend and fellow prisoner was told by staff in his cell at around 8.30am that morning. Once they realised that he was friends with the man, they said someone would come to talk to him shortly. The man's friend said no one came to talk to him but later that afternoon he was asked to go to the wing office with the SO to see the duty governor.
146. The duty governor said he had become aware of a rumour from prisoners that the man had discussed feelings of suicide with the SO on his wing and his friend had been telling prisoners this. The SO said that the man had come to the wing office to speak to him a couple of days before. They had discussed how he was feeling and the SO had asked the man whether he needed to open a "book" (meaning ACCT documentation). The SO told the duty governor that the man had told him he did not feel like harming himself.
147. The duty governor said that the man's friend had then said that the conversation he had with the man must have been a misunderstanding. He was satisfied with this. The man's friend said that only then did staff ask him how he was feeling. He wrote to the investigator after their interview on 18 April. He said that if his friend had told the SO he was thinking about suicide, he believed the SO would have made him subject to monitoring under the ACCT procedures.
148. A prisoner later said he heard what he thought was a chair being thrown across the cell above him (the man's cell) at 11.50pm. The next noise he heard was what he thought was the same chair being moved the following morning at 6.10am. Another prisoner heard a chair being moved around the same time from a cell near to his.
149. On 2 February, a memorial service for the man was held at the prison, attended by over 66 prisoners, staff, family and the IMB.

ISSUES

Clinical care: physical health

150. At various times during his imprisonment, the man was treated by the healthcare department for injuries, other physical ailments and mental health problems. The clinical reviewer writes:

“ ... in terms of physical health care, [the man’s] treatment and care was equitable with the care he would have received in the wider community. This is evidenced by appropriate referrals to acute hospital units for accidents and self inflicted injuries and timely hospital in patient admission due to possible appendicitis.”

151. However, on two occasions in April and December 2011, injuries received by the man were not recorded in his clinical record at the time they happened. We make the following recommendation:

The Head of Healthcare at North Sea Camp should ensure all prisoners’ injuries and healthcare-related events are documented in their clinical record.

Decision to transfer the man from North Sea Camp

152. On 9 January, the man absconded from North Sea Camp and expressed thoughts of suicide. He returned to the prison later that morning. A concern and keep safe form was completed at 12.15pm, along with an immediate action plan 30 minutes later. It was decided that he should be transferred to closed conditions at Lincoln. This was due to his risk of absconding and mental state. He left North Sea Camp at 1.45pm. It was clearly annotated on the man’s ACCT document that he was to remain a category D prisoner and the full ACCT assessment was to be completed on reception at Lincoln.
153. In view of the security issues involved, we believe the decision to transfer the man to a closed prison, before the full ACCT assessment was completed, was reasonable.

Initial ACCT assessment

154. The man arrived at Lincoln with the concern and keep safe form at 3.45pm on 9 January. Prison Service Order (PSO) 2700, suicide and self-harm prevention was the guidance in force at the time. (This has since been replaced with PSI 64/2011.) The PSO stated that an ACCT assessor must be notified that the ACCT plan has been opened and an assessor must interview a prisoner within 24 hours of this form being completed. The PSO also instructed that an ACCT case review must take place within 24 hours of a prisoner’s arrival at a prison and a case manager must be appointed. The unit manager or night orderly officer must ensure that this referral for assessment and the first case review occurs and keeps the prisoner safe pending the assessment and first case review.

155. The man's ACCT assessment should have taken place by 12.15pm on 10 January. A case review should have taken place, a case manager appointed and arrangements made to keep the man safe pending this assessment. Aside from a reception healthscreen, none of this was done. On 10 January, around 2.00pm, an SO discovered the man in his cell with deep cuts to his wrist. He told the SO that this was an attempt to end his life. He was treated by a nurse and assessed by a mental health nurse later that afternoon. The SO then intended to complete the man's ACCT assessment but had to postpone this as his wound had reopened. He was taken to hospital to have the injury stitched at 4.20pm and returned to the prison at 7.00pm.
156. On the man's return, a full ACCT assessment and case review took place with two SO's. During the assessment, the man told the SO that he had needed "an outlet" but now felt he had the support he needed from staff and the mental health team. We are extremely concerned that it seemingly took the man making an attempt to end his life to get the attention of staff and the care he needed.
157. PSO 2700 states that:

"Where an ACCT Plan is already open and the prisoner self-harms, unless the CAREMAP states otherwise, the Case Manager must be informed about the incident and an ACCT case review must be held as soon as possible (i.e. within two hours, or twelve hours if the incident occurs at night) ... If the prisoner is taken to hospital, the ACCT Plan must travel with them ... A case review will still take place as required above to decide what, if any, action is required by the establishment at that time. Once it is known when the prisoner is to be discharged from hospital, a case review must be held in time to prepare an updated CAREMAP for his/her return to the establishment. Where possible this should involve appropriate specialist input (in person, in writing or by telephone) from hospital staff."

The case review and CAREMAP were not completed before the man returned to Lincoln as he had still not had his initial assessment completed at this stage.

158. The safer custody manager prepared a monthly rota for staff completing ACCT assessments. Two members of staff are allocated to complete such assessments each day. The investigator checked these rotas and the SO (who completed the assessment) was not one of the four staff detailed. The safer custody manager confirmed that all four staff were in the prison on the two days in question.
159. The safer custody manager said that the initial ACCT assessment should have taken place the evening that the man arrived. When he arrived in reception, the officer who received him should have noted that it was outstanding and informed the orderly officer. They, in turn, should have written it on the daily diary sheet to which all staff have access and told the ACCT assessor on duty that an assessment was needed. The safer custody manager said that, depending on the urgency of the assessment, the orderly

officer could then arrange cover for the ACCT assessor's other duties so that this assessment could be completed as soon as possible.

160. The man's name was entered in the diary for assessment on 10 January. It is not possible to determine who put this in the diary or when. His name was not recorded on the daily briefing sheet on 10 January, which lists all prisoners subject to ACCT measures or who require post-closure reviews. The safer custody manager would have expected his name to appear here if the process had been correctly followed the day before.
161. The procedures at Lincoln for receiving prisoners at risk of self-harm or suicide and keeping them safe were not followed in this man's case. It is a concern that nearly 24 hours after he arrived at Lincoln, he made an attempt to end his life before he had been assessed by a qualified member of staff, as he should have been had the process been adhered to.
162. Four ACCT case reviews were held, the first on 10 January, after the man had harmed himself and had been treated in hospital. At that time, his risk was assessed as raised but, after the second review the following day and two subsequent reviews, it was assessed as low. It is hard to understand how a prisoner's risk would be regarded as low the day after such a serious act of self-harm. In making their judgement, staff seemed to rely entirely on the man's appearance of being more "upbeat" and his assertion that he had no thoughts of self-harm. It is notable that his prison-based offender supervisor considered that he sometimes pretended to cope. We would consider that reducing prisoners' assessed risk to low the day after they have severely harmed themselves is too soon and that staff should allow a further period to monitor non-verbal behaviour. We make recommendations about the ACCT process below.

Closure of ACCT at Lincoln

163. On 13 January, the third ACCT case review noted that the man's mood had improved and "book to be closed at next review". This was just three days after he had cut his wrists in a serious suicide attempt. At the next case review, on 17 January, the ACCT was closed. This case review recorded his risk of suicide or self-harm was dependent upon his return to North Sea Camp (which at the previous review had been noted as scheduled for 19 January) and that if this did not occur they would re-evaluate. No such re-evaluation took place.
164. Some of the original CAREMAP objectives were based on the man's return to North Sea Camp. They included the deputy governor liaising with his offender manager regarding his release address and referring him for mental health input at North Sea Camp. These had not been fulfilled while he remained at Lincoln.
165. PSO 2700 states that ACCT plans must not be closed within 72 hours of a known transfer to another establishment. Furthermore, staff should only close the ACCT plan once all the CAREMAP actions have been completed and:

“... the Case Review Team judges that it is safe to do so, i.e. that the problems that caused the ACCT Plan to be opened have been resolved or reduced, the prisoner is able to cope with any remaining difficulties, they have access to and are making use of at least some positives, e.g. friends, family, counsellor, member of chaplaincy team, hobbies, education/employment, and they know who to contact (and how) should they need support in the future.”

166. Several healthcare and discipline staff, as well as the man, believed he would return to North Sea Camp on 19 January, ten days after he had arrived at Lincoln. In view of this, and the fact that the final case review was taking place within 72 hours of this potential transfer, in line with PSO 2700 it should not have been closed.
167. Furthermore, some of the CAREMAP actions had been listed for completion by North Sea Camp and this would not be done until the man returned there. While we accept that his mood appears to have improved, these issues needed to be resolved before the closure of the ACCT plan. It is also a concern that the case review on 13 January noted that the ACCT would be closed at the next review which appears to have prejudged the next review. This is clearly against the ethos of the ACCT process, which aims to monitor the prisoner's risk of self-harm at the time rather than making predictions about whether this risk will have reduced in the future.
168. There were a number of failings in the management of the ACCT procedures at Lincoln. At the case review on 13 January, prison staff should certainly not have pre-empted the outcome of the forthcoming review. We believe that they should have continued supporting the man and that the ACCT plan should not have been closed on 17 January.

The Governor of Lincoln should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **conducting prisoner assessments promptly;**
- **ensuring that prisoners transferred to Lincoln while subject to ACCT procedures are assigned a case manager and appropriate arrangements are made for their first night in prison;**
- **ensuring that the assessment of risk takes account of all the prisoners' circumstances and risk factors and not just their personal presentation;**
- **ensuring that ACCT monitoring is not stopped if the CAREMAP objectives have not been fulfilled or within 72 hours of a transfer to another prison.**

Transfer to Stafford

169. On 18 January 2012, the duty governor at North Sea Camp telephoned the duty governor at Stafford to arrange for the man to transfer to Stafford. The duty governor at North Sea Camp told the investigator this was due to a policy of returning a prisoner to their original prison. We have been unable to find written confirmation of such a policy. However, we are not critical of the man's transfer to Stafford. From speaking to staff and prisoners, it appears that if he could not return to North Sea Camp, Stafford was the best option as he was familiar with the prison.
170. There are, however, questions about the way the man's transfer was managed. Governors at North Sea Camp, Lincoln and Stafford were all involved in the decision to transfer him to Stafford on 18 January. On 19 January it was confirmed that this move would take place the following day. He subsequently told his mother he did not know that he was going to Stafford until staff collected him from his cell on the morning of 20 January.
171. This would be far from ideal in most circumstances, but in this man's case he was expecting to return to North Sea Camp after ten days at Lincoln. It has not been possible to determine exactly how this expectation arose but it seems to have been the understanding of all those involved at the time. A governor from North Sea Camp rang the man's mother on the day he transferred to Lincoln and told her the same thing. It was the clear impression at Lincoln that he would return to North Sea Camp, and his return there was central to assessments made about his risk of suicide and self-harm and was documented on the ACCT.
172. During their telephone conversation on 18 January, the duty governor at North Sea Camp said he told the man at Stafford that an ACCT had recently been closed. The duty governor at Stafford denied this and said he would have told the safer custody department and other governors involved in the transfer had he been aware of this.
173. The duty governor at Stafford told the investigator that, following his conversation with the duty governor at North Sea Camp, he had expected the man's transfer then to be arranged by the offender management unit and for him to go there in a taxi with escort officers. He had also expected a further conversation to occur with North Sea Camp about the man's transfer once all the arrangements had been made. This was because he was a returning IPP prisoner which was unusual. The duty governor at North Sea Camp said that the man returned on the escort van in the usual manner since he was no longer subject to ACCT monitoring. It is unclear why the OMUs at both prisons were not involved in the transfer which would have allowed for a more considered transfer and an agreed method of transport.
174. PSO 2700 instructs that:
- "The intention to transfer a prisoner on an open ACCT Plan (or in the post-closure phase of ACCT) must be discussed with the receiving

establishment, a record must be retained in the sending establishment to show this has been done (as well a record made in the ACCT Plan), and relevant information must be conveyed either with or ahead of the prisoner ...

“The proposed transfer, and issues arising from it, must be discussed at a case review with the prisoner ... The prisoner should be given information about the regime and facilities of the new establishment, helped to prepare, and subject to security considerations, given the opportunity to contact family and friends prior to the transfer.”

175. Clearly the man was given no such opportunities. While the transfer was arranged at a governor level, no one communicated this to wing or healthcare staff or, more importantly, to the man himself. No case review took place, nor was a record made in the man’s ACCT plan that any discussion regarding his risk of suicide or self harm had taken place between prisons. We recommend the following:

The Governors of North Sea Camp, Lincoln and Stafford should ensure that staff adhere to policy instructions when transferring prisoners subject to ACCT arrangements.

Transfer of ACCT documents

176. PSO 2700 instructs that when a prisoner whose post-closure review has not taken place is moving to another place of custody, such as another prison or a court, the closed ACCT plan must accompany him; the discharging reception staff must make receiving escort staff aware that the prisoner has a recently closed ACCT Plan and this must be recorded on the PER.
177. The PSO goes on to say that:
- “Risk is increased by failure to adequately inform those taking over responsibility for prisoners on transfer to another place of custody about levels of risk, likely triggers of increased risk, and existing care plans, all of which enables continuation of care.”
178. The man’s ACCT documents did not travel with him from Lincoln to Stafford. Due to an administrative error, safer custody staff at Lincoln (who would have been responsible for sending the documents) were not informed that he was due to transfer. In addition, as previously discussed, a case review had not been completed before the transfer which would also have highlighted the need to transfer the documents.
179. The manager of the safer custody department said that the security department should have informed safer custody that the man was due to transfer from Lincoln. As his transfer had only been agreed the day before, it would be regarded as a “late transfer” and would not be subject to the usual process where safer custody check the daily diary sheet. Had this occurred, the safer custody department would have had the opportunity to contact their

counterparts at Stafford before the man's transfer and also ensured that his ACCT documents travelled with him.

180. An administration officer at Lincoln had instructed the two officers who dealt with the movement of prisoners that if a prisoner is due to transfer, any alerts for ACCT documentation must be checked and safer custody informed. The investigator spoke to the head of security at Lincoln. He acknowledged that a more robust system was needed for informing safer custody about late transfers. He explained that if the man had transferred in a taxi, safer custody would have been informed as part of the risk assessment. Or, as a contingency, staff completing the PER form in reception should check that the ACCT documents accompany the prisoner and obtain them if they are not already there.
181. Stafford's deputy governor told the investigator that it is quite common for prisoners to arrive without their ACCT documents. He had raised the issue at safer custody meetings and they tried to ensure that all transfers go through the safer custody departments in the sending and receiving prisons.

The Governor of Lincoln should ensure that ACCT documents accompany all transferring prisoners.

Stafford's care and assessment of the man's risk of suicide and self-harm

182. The clinical reviewer writes:

"In terms of [the man's] mental health needs, mental health risk assessment by healthcare staff at HMP Stafford could have been more robust taking into account [the man's] very recent history of self harm and the fact that he was in the Post Closure Phase of an ACCT. It appears from the System 1 patient records that the incident of self harm on 10th January 2012 was considered in isolation as an episode having happened in the past and not pertinent to his state of mind on admission to HMP Stafford. There was also the increase in risk factors for self harm ... There appeared to be a reliance on prisoners 'self reporting' that he had no intention of repeated self harm."

183. The clinical reviewer concludes that there were "several missed opportunities for intervention which may have instigated further action by healthcare staff at the prisons". For example, when the man transferred back to Stafford the reception nurse did not review his clinical record. It is difficult to determine whether this was because it had not been released by the sending prison; whether he did not have time; or whether it was an omission on his part. Had this information been reviewed, the nurse would have had a much more accurate idea of the concerns facing the man and the fact that his transfer to Stafford in itself was central to his risk of self-harm and suicide and was likely to have increased his risk.
184. PSO 2700 states that, "Staff have a responsibility to ensure they are aware of which prisoners in their care are on an open ACCT Plan, and what the key

requirements of that plan are. The PSO also says that reception staff must be aware of the increased risk of suicide and self-harm if there is a change of status, talk to these prisoners and maintain a record. Although the man had technically maintained his category D status pending an investigation by PPCS, he seemed unaware of this. A move from an open prison back to a closed establishment is a significant event for an indeterminate sentenced prisoner. The reception SO, reception nurse and a wing SO discussed with the man how he was feeling about returning to Stafford. He denied any issues. Further assessment was clearly made more difficult by the absence of the ACCT documents. We agree with the clinical reviewer's conclusion that further consideration could have been given to assessing the man's risk of suicide given his history and risk factors.

185. On 26 January, the man was assessed by a doctor who referred him to a mental health nurse. A TAG assessment showed his risk of self-harm and suicide had increased since his reception at the prison, although this original assessment was not reviewed by the nurse. He also told the nurse that he has "no active thoughts to self harm at present, but is struggling daily. Feels he is having a breakdown." We agree with the clinical reviewer's conclusion that:

"Collectively the information obtained may potentially have increased the risk of self harm and may have been a missed opportunity for further intervention at that point ...

"It is important that all events relevant to the care of at-risk prisoners are appropriately noted in ACCT Plans and that colleagues are aware of what has happened and what the risks are. All staff (whether healthcare, operational or other) have responsibility for the maintenance of ACCT Plans of prisoners they come into contact with, and a responsibility to share risk information with others caring for the prisoner."

186. The SO who worked on the man's wing said that wing staff were not aware of some of the man's concerns until after his death, including the reasons for his transfer. Although wing staff at Stafford never had access to the ACCT documents for the man, much of the information regarding case reviews and closure of the ACCT was contained in healthcare records. Healthcare staff did not volunteer this information, nor did prison staff request it. Some managers involved in the transfer also had more information about the man than those working with him on the wing.
187. The deputy governor told the investigator that since the man's death, Stafford have introduced a form to be completed by officers on night duty on the day a prisoner arrives. This indicates all factors related to an increase in suicide and self-harm and is sent to the induction wing for them to take into consideration when dealing with the prisoner. We welcome this introduction.

The Governor and Head of Healthcare at Stafford should ensure that staff follow the national guidelines in risk assessing and managing a prisoner's risk of self-harm and suicide.

Communication

188. During the man's last weeks in custody there was a lack of clarity in both written and verbal communication between prisons, amongst staff in the same prison and with the man. He had cut his wrist in an attempt to end his life the day after he arrived at Lincoln and his ACCT assessment had been delayed as a result of poor communication.
189. It appears that the man genuinely believed that he would return to North Sea Camp after ten days at Lincoln prison. This was also communicated to his mother and wing staff at Lincoln also believed this to be the case. Moreover, his return to North Sea Camp would appear to have been crucial to reducing his risk of suicide and self-harm.
190. However, following arrangements between governors at Lincoln, North Sea Camp and Stafford, the man transferred to Stafford on 20 January with no prior warning. While at Stafford, he asked a number of staff whether he had been reclassified and had lost his category D status. Staff were unable to give him a definitive answer. The duty governor at Stafford told the investigator that he had expected the man to arrive with an 'RC1' form to indicate he had been recategorised from a category D to category C prisoner. He said this would normally be signed off by a Governor at the sending prison and asked an officer to try and find it in the man's file.
191. In fact, the man had not been recategorised and remained a category D prisoner pending a review by the PPCS to which he could make representations by 23 February. A letter had been sent to him with this information on 26 January. It is clear from the investigator's discussions with the duty governor and deputy governor at North Sea Camp that they were aware of this and the man's offender supervisor also believed he would have to be assessed by the Parole Board.
192. This information was not apparent to the man or staff at Stafford, including the duty governor who had been involved in his transfer. The man seemed to be preoccupied with whether he had been recategorised and said he could cope if he had but needed to get a decision either way. It is disappointing that this information does not appear to have been conveyed to either him or Stafford prison. We are also concerned that Stafford and Lincoln prisons were unaware of the procedure with PPCS when a prisoner fails in a category D establishment and there is no evidence to suggest they contacted North Sea Camp to obtain this information.

The Governor of North Sea Camp should ensure that staff make it clear when transferring an indeterminate sentenced prisoner back to closed conditions that the prisoner and the receiving establishment understand the reasons for transfer, any changes to categorisation and the process for any future moves.

The Governors of Lincoln and Stafford should ensure that staff are fully aware of and follow the policy to manage prisoners who have failed in category D conditions.

Completion of post-closure review

193. Despite not arriving with his ACCT documents, staff at Stafford quickly realised that the man had recently been subject to ACCT monitoring and contacted Lincoln to get them. The SO in reception obtained the date on which the ACCT had been closed (17 January) and the date the post-closure review was due (24 January). She rang the SO on the induction wing to make him aware of this. He recorded the information on the man's case record and the wing observation book, although the date he entered on the man's case record was one day out of date (18 January).
194. PSO 2700 states that:
- “When receiving a prisoner in the post-closure phase of ACCT (i.e. the ACCT Plan has been closed, but the final post-closure review has not been signed off) the receiving Unit Manager must nominate a Case Manager (or undertake the role themselves) to oversee the continuing closure process.
- “The Case Manager must enter in the record of the final Case Review why the Case Review Team feel it is safe to close the ACCT Plan, and enter the date closed and date for a post closure interview. The date of the first post closure interview is a matter for the case review team to decide but must be within 7 days of closure. The timing of further post closure interviews (there may be as many such interviews as felt necessary) is decided at the preceding interview, though the Case Manager can bring this forward whenever increased risk is reported.”
195. The SO on E wing said that the same system was in operation throughout the prison whereby each wing office had a wipe board listing prisoners subject to ACCT monitoring and their review dates. The man's post-closure review should have been annotated on the wipe board as well as in the post-closure tray and the wing SO should have carried out the post-closure review.
196. An SO was the main manager allocated to the induction wing for the week that the man was at Stafford and accepted he had overall responsibility for ensuring the post-closure review was completed. The SO told the investigator that, although he was aware a post-closure review was due from reading the observation book, he did not know when as he did not have the ACCT documents. He said the timing could vary according to why the ACCT was closed and the prisoner's issues. He said it could be seven days after an ACCT was closed or longer and would be set by those present when the ACCT was closed.
197. The SO was not familiar with the PSO guidance that the post-closure review had to take place within seven days. A further SO had indicated that the

man's ACCT had been closed on 18 January on his core record and the SO could have accessed this information, thus calculating that the post closure review was due by 25 January (one day later than had actually been scheduled).

198. The SO said he did not contact healthcare staff to obtain the date of the post-closure review as he did not think they would know. He did not enter the information on the ACCT board in the wing office or the tray for the post-closure reviews for this reason. He said he could have contacted the safer custody department but he did not think the officer was on duty. The SO commented, "I think if we'd have had the ACCT document then I think we'd have been able to do more". The officer who conducted the second day interview with the man also told the investigator, "I think the fact that we never saw his ACCT document probably meant it wasn't at the forefront of our minds".

The Governor of Stafford should ensure that staff conduct ACCT case reviews and post-closure reviews in accordance with national policy and guidelines.

ACCT documents received at Stafford

199. Lincoln faxed the man's ACCT documents to Stafford at 3.30pm on the afternoon he arrived. This fax was picked up straight away but after the administration assistant consulted with E wing and the OMU she was told to put it in the OMU tray. As it was thought to be for information only, this faxed document was then placed in the man's file by an administration assistant and never seen by staff working directly with him.
200. The posted copy of the man's ACCT documents arrived at the post room at Stafford on 24 January. There is some dispute over whether the post room contacted the safer custody co-ordinator to collect them the same day or two days later. In any event, they remained on his desk until after the man had died.
201. At the time of the man's death, if post was addressed to the safer custody department, only the safer custody co-ordinator would be contacted to collect it. If he was not on duty that day or week the post would remain uncollected. The Governor has now amended this to include in the duty governor's responsibilities collecting the safer custody team's post if the safer custody co-ordinator is not in the prison that day.
202. The safer custody co-ordinator told the investigator that ACCTs were not often sent to him. As the man's ACCT was closed, he did not consider it to be urgent. He did not check the triggers page or the date of closure or that a post-closure review was needed. He said that, in the future, he would make sure that ACCTs were opened when received and taken personally to the wing where the prisoner was located. He explained to the investigator that, he had not paid sufficient attention to this.

The Governor of Stafford should ensure that faxes and post, particularly those relating to safer custody, are processed and distributed promptly.

Telephone calls to the prison

203. The man's stepfather telephoned the prison switchboard on 25 January and asked to speak to two different SOs or a governor as he was concerned about his stepson's welfare. He was told he would have to put his request and concerns in writing and was not offered any further help or advice.
204. The deputy and duty governors both told the investigator that the person operating the switchboard should have put the man's stepfather through to the duty governor that day. No request in writing is necessary. The deputy governor has since spoken to all switchboard operators and is confident that they would now put a caller through to the duty governor if the person said they were concerned for a prisoner's welfare. This is in line with PSO 2700 which states that:

"Agencies and individuals outside of prison can help with warnings, assessment and referral. Establishments must have in place robust systems for receiving and recording, and passing to the area of the prison where the prisoner resides, information coming into the establishment from families, agencies, Offender Managers/Supervisors and other parties outside the establishment who have a concern for a prisoner who may be at risk of self-harm or suicide."

205. It is regrettable that the man's stepfather was unable to speak to a manager that day about his concerns for his stepson. Information from families is vital when trying to assess risk.

The Governor of Stafford should ensure that staff record and pass to the duty governor urgently concerns about a prisoner's risk of self-harm or suicide received from agencies and individuals outside of prison.

Emergency Code

206. Staff reacted quickly, calmly and competently when the man was discovered. Discipline staff attempted CPR but made an appropriate decision to stop once they realised he could not be saved. An ambulance arrived at the prison five minutes after the man was found and he was pronounced dead 18 minutes later.
207. All the discipline staff interviewed, apart from one, said there was no emergency code system at Stafford. The member of staff who believed there was an emergency code system in place could not recall any details of emergency codes. It is good practice for a prison to operate an emergency code system. This informs staff not only that there is an emergency but also of its nature and enables them to better prepare, including taking the correct emergency equipment.

208. The deputy governor confirmed that there is no emergency code system in place at Stafford. Staff are expected to raise the alarm via communications by calling a medical emergency which is what happened when the OSG found the man. By contrast, South Staffordshire PCT's CPR policy states that prison staff will raise the alarm using an emergency code blue or red for healthcare to respond.
209. In this instance, no healthcare staff were in the prison, as 24 hour nursing cover is not provided. Nevertheless, given the PCT's expectation that a code system will be used, we make the following recommendation, which we have also made in the death which followed that of the man:

The Governor at Stafford should ensure an emergency code system is introduced.

Staff and prisoner support

210. Most staff said they had felt well supported following the man's death. However, two members of staff said they had not been told about his death until they arrived on the wing where he died the following morning. They also felt unsupported by the senior management team whom they did not see until that afternoon. One member of staff said he felt isolated and was unsure whether he was emotionally fit to be working at the time.
211. Although we note that debriefs took place as required and the staff care team were involved, it is important that all staff are included in such follow-up arrangements and management presence is seen on the wing.
212. The man's closest friend in prison was told about his death in his cell. On realising they had been friends, staff said they would return to offer him support that morning. This did not happen and that afternoon, he was questioned about what the man had told him before staff finally checked on his welfare.

The Governor of Stafford should ensure that all staff and prisoners are appropriately supported following a death in custody.

CONCLUSION

213. The gentleman was a young man who, for a number of years, progressed well in the prison system and seemed to be working towards his eventual release. However, following a decline in his mental health, he absconded from North Sea Camp and was transferred to a more secure prison, Lincoln. He then moved to Stafford prison with no prior warning, a prison where he had previously spent some of his sentence.
214. Although the man's risk of suicide and self-harm was assessed on a number of occasions at these three establishments, some of the assessments were insufficiently robust or timely. In particular, there was a need to fully re-assess his risk when he was transferred to Stafford but this did not happen. Important information was not passed between prisons and he was not kept well informed of his situation and he became increasingly frustrated with the lack of clarity.
215. While it is impossible to determine if better communication and management of the suicide and self-harm prevention processes would have prevented the man from apparently taking his own life, such information sharing in managing prisoners' risk is vital to ensure appropriate risk assessment and support is proposed.

RECOMMENDATIONS

1. The Head of Healthcare at North Sea Camp should ensure all prisoners' injuries and healthcare-related events are documented in their clinical record.

North Sea Camp has accepted this recommendation. All prisoner injuries are recorded on F213 and recorded in patient notes. Staff have been re-advised to ensure that this is completed with all injuries.

2. The Governor of Lincoln should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - conducting prisoner assessments promptly;
 - ensuring that prisoners transferred to Lincoln while subject to ACCT procedures are assigned a case manager and appropriate arrangements are made for their first night in prison;
 - ensuring that the assessment of risk takes account of all the prisoners' circumstances and risk factors and not just their personal presentation;
 - ensuring that ACCT monitoring is not stopped if the CAREMAP objectives have not been fulfilled or within 72 hours of a transfer to another prison.

Lincoln has accepted this recommendation. Residential wing managers will check all ACCT documentation at the start of their duty to establish if reviews (including post closure) or assessments are due. This check will be documented and signed for within the wing diary and a more senior manager will make a daily check on the previous day's entries to ensure that this has been completed.

The Reception manager will be responsible for ensuring that all open ACCTs are checked at the point of reception and they will have responsibility for notifying both the Orderly Officer and the wing manager that a prisoner has arrived on an open ACCT. This will be recorded in the Reception diary and the previous day's entries will be checked daily by a more senior manager i.e. Duty Governor.

All Senior Officers at HMP Lincoln are trained as Case Managers. The Wing Senior Officer on the day of the prisoner's arrival will act as Case Manager for that prisoner's ACCT reviews and will be the first point of contact.

The Senior Officer on A wing, and E wing in the case of a Vulnerable Prisoner (VP), will ensure that prisoners received into custody on an Open ACCT document are interviewed by staff prior to evening lock-up. This will be documented in the handover section of the wing diary.

Refresher training will be undertaken by all Case Managers, including Temporary promoted Senior Officers and Principal Officers. In addition ACCT will be a standing item at Residential Senior Officer meetings.

3. The Governors of North Sea Camp, Lincoln and Stafford should ensure that staff adhere to policy instructions when transferring prisoners subject to ACCT arrangements.

North Sea Camp has accepted this recommendation. A Notice to Staff 107-12 dated 17th August 2012 was published reminding all staff of the requirements of PSI 64/2011 when transferring prisoners on an open ACCT. This will ensure that the prisoner being transferred fully understands and is prepared for their new establishment and that the receiving establishment is aware of the needs of the prisoner and reasons behind the transfer.

Lincoln has accepted this recommendation. A presentation about this area of policy will be made at a full staff briefing. In addition, ACCT will be a standing item at Residential Senior Officer meetings. Refresher training will be undertaken by all Case Managers, including Temporary promoted Senior Officers and Principal Officers.

Stafford has accepted this recommendation. A notice to staff has been issued regarding the transfer in and out of prisoners subject to ACCT.

4. The Governor of Lincoln should ensure that ACCT documents accompany all transferring prisoners.

Lincoln has accepted this recommendation. OCA staff, and/or Security staff, arranging for the transfer of a prisoner will check with the Safer Custody A.O. and also the ACCT register on the Z Drive, for any prisoners who are currently on an ACCT, or in Post closure stage. They will acknowledge that they have done so on the relevant department diary page.

On the day of transfer the SO in reception will, as part of the discharge procedure, confirm if a prisoner is currently subject to an open ACCT or in Post Closure stage. This check will be confirmed on the discharge checklist.

All prisoners subject to open ACCT and/or in Post closure stage will be accompanied by the relevant ACCT documentation.

5. The Governor and Head of Healthcare at Stafford should ensure that staff follow the national guidelines in risk assessing and managing a prisoner's risk of self-harm and suicide.

Stafford has accepted this recommendation. A notice to staff has been issued regarding the management of prisoners at risk of self-harm.

6. The Governor of North Sea Camp should ensure that staff make it clear when transferring an indeterminate sentenced prisoner back to closed conditions

that the prisoner and the receiving establishment understand the reasons for transfer, categorisation and the process for any future moves.

North Sea Camp has accepted this recommendation. Following receipt of the PPO's draft report the Functional Head responsible for the Offender Management Unit put in place a system whereby all indeterminate sentenced prisoners would be given a letter setting out the reasons why they were being transferred back to closed conditions and details of their on-going management. This is the responsibility of the Offender Supervisor responsible for the prisoner's case.

7. The Governors of Lincoln and Stafford should ensure that staff are fully aware of and follow the policy to manage prisoners who have failed in category D conditions.

Lincoln has accepted this recommendation. The Lifer Liaison Officers print off a list of prisoners from Prison-NOMIS each day. This informs them of all relevant prisoners at HMP Lincoln and enables them to check on any new transfers from open conditions. They liaise with the sending establishment or Duty Governor at HMP Lincoln to ascertain the reason for the transfer. They also meet with the prisoner to issue the LISP 4 when it has been received from the sending establishment. The decision to change the categorisation from D to C is then determined by the Parole Board at the relevant hearing (paper or oral).

Stafford has accepted this recommendation. A notice will be issued advising staff of the requirements when prisoners are received from other establishments, in particular Category D, and the need to be aware of the potential heightened risk of self-harm for the prisoners received. In addition, the Safer Custody Manager will provide awareness guidance to reception staff.

8. The Governor of Stafford should ensure that staff conduct ACCT case reviews and post-closure reviews in accordance with national policy and guidelines.

Stafford has accepted this recommendation. A notice to staff has been issued advising them of the importance of adhering to correct procedures. Case reviews are now routinely discussed at the morning SMT meetings and individuals identified to manage them.

9. The Governor of Stafford should ensure that faxes and post, particularly those relating to safer custody, are processed and distributed promptly.

Stafford has accepted this recommendation. A notice to staff has been issued advising of the need to pass on such information to the appropriate department immediately. Additionally, meetings have been held with those working in areas that receive such information to ensure that staff fully understand the importance of this. A procedure has been introduced to ensure that fax machines are checked for information outside office hours.

10. The Governor of Stafford should ensure that staff record and pass to the duty governor urgently concerns about a prisoner's risk of self-harm or suicide received from agencies and individuals outside of prison.

Stafford has accepted this recommendation. A notice to staff has been issued advising of the need to pass on such information to the Duty Governor. Additionally meetings have been held with those working in areas that receive such information to ensure that fully understand the importance of this.

11. The Governor at Stafford should ensure an emergency code system is introduced.

Stafford has accepted this recommendation. An emergency code system has now been introduced.

12. The Governor of Stafford should ensure that all staff and prisoners are appropriately supported following a death in custody.

Stafford has accepted this recommendation. A hot debrief and two critical incident debriefs were held following this death. The care team are always available for those who need support. A notice was issued to staff and prisoners advising them that support was available to all if required. Stafford will continue to offer such support for this and future incidents.