



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at HMP Peterborough in November 2013**

Our Vision

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

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Peterborough in November 2013. I offer my condolences to his family and friends.

One of my investigators and the clinical reviewer reviewed the man's clinical care in prison. The prison cooperated fully with this investigation.

In October 2013, police twice took the man to hospital under Mental Health Act powers because of fears he was suicidal as a result of marital problems. Both times, he was assessed and discharged from hospital the same day. His GP made an urgent appointment for the community mental health team to assess him on 31 October, but on 28 October he was arrested and charged with arson after setting a fire at his home. The man was constantly watched in the police station. The next day, he was remanded in custody and sent to HMP Peterborough. He had never been to prison before.

The man arrived at Peterborough with a suicide and self-harm warning form which had been raised at court and had a number of factors that indicated a raised risk of suicide or self-harm. Despite this, reception staff at Peterborough did not assess him as a risk and begin suicide and self-harm prevention procedures. Additional information about his risk was also not acted on, including concerns from his GP about his mental state. On 11 November, the man was served with an order preventing him from having contact with his wife. He was convicted on 13 November and his solicitor told him to expect a sentence of seven years. He also learned that his ex-wife did not want his daughter to visit him in prison. Again no one identified him as at risk of suicide and self-harm when he returned to the prison. He was found hanged in his cell two days later.

I am very concerned that reception staff and then others at the prison did not properly consider the man's risk factors. This meant that he was not given the support he needed. Indeed, it is difficult to understand how so many known risk factors could have been discounted, including the suicide and self-harm warning from the court. This was his first time in prison, he had recently been sectioned under the Mental Health Act, he had been charged with arson, and he had relationship difficulties. All of these are known risk factors which should have alerted staff, who appear to have placed too much reliance on his assertions that he would not harm himself and his preference not to be monitored. I am also concerned that the mental health alert system did not work effectively. The Director needs to ensure that all the staff have a better understanding of risk factors for suicide and begin monitoring when high risk is identified.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2014

CONTENTS

Summary

The investigation process

HMP Peterborough

Key events

Issues

Recommendations

Action Plan

SUMMARY

1. On 20 and 27 October 2013, the man was sectioned under section 136 of the Mental Health Act 1983 after making threats to harm himself. On both occasions he was assessed at hospital by two psychiatrists and released the same day.
2. On 28 October, he was arrested and charged with arson after he set fire to his home during telephone call with his father-in-law. He spent the night in a police station where he was constantly observed. The next day, he appeared at Cambridge Magistrates' Court and was remanded into custody. A suicide and self-harm warning form was opened at court because his mood was low and because his actions in setting the fire appeared to be directed at himself. He had no previous criminal record.
3. The man arrived at HMP Peterborough on 29 October. Although reception staff considered some of his risks factors, they decided not to open an ACCT (Prison Service suicide and self-harm prevention procedures) as the man assured them he did not intend to harm himself. The man's GP notes were faxed to the prison on 30 October and read by a prison GP, who also decided not to open an ACCT. The man talked to a number of staff and prisoners about his situation, but none were concerned he was at risk of suicide or self-harm.
4. On Sunday 3 November, at the request of wing staff, a mental health nurse saw the man who was anxious and wanted someone to talk to. This was contrary to guidance for weekend duty mental health nurses who were told just to advise wing staff about prisoners who had not yet been assessed, rather than visit them. The nurse said she had planned that the man should be seen again after a court appearance on 5 November and noted that she had advised the wing Senior Officer to complete an alert form for the mental health in-reach team. (An investigation conducted by Cambridgeshire and Peterborough Foundation Trust, about the nurse's contact with the man, recommended that the nurse face a formal disciplinary hearing which, at the time of writing, had not taken place.)
5. On 6 November, night staff became concerned about the man's mental state after he wrote a strange letter of apology to the fire service. The night duty nurse completed an alert form with the intention that the man should be assessed as soon as possible by the mental health in-reach team. The nurse did not mark the alert form as urgent and no one from the mental health in-reach team saw the man before he died.
6. On 11 November, the man was served with an order preventing him from having contact with his wife. He was convicted of arson on 13 November. When he was at court he heard a victim impact statement from his ex-wife in which she said she did not want his daughter to visit him in prison. He was told that he should expect a sentence of about seven years. The man did not tell staff what happened at court. Prisoners described him as unusually cheerful that evening. On 14 November, a member of the IMB spoke to the

man and was worried about his state of mind so contacted someone from the prison's safer custody team. She had been reassured that the safer custody team said that they knew about the man and were keeping an eye on him.

7. At 4.09am on 15 November, a night patrol officer found the man hanging in his cell. The emergency response was swift and, although it appeared that the man had been dead for some time, prison staff attempted resuscitation. Paramedics pronounced the man dead, shortly after they arrived.
8. We make recommendations about the assessment of risk, ACCT training, the process for mental health alerts and guidance on when resuscitation is inappropriate.

THE INVESTIGATION PROCESS

9. The investigator issued notices about the investigation to staff and prisoners at HMP Peterborough inviting anyone with information to contact her. One prisoner responded.
10. The investigator visited Peterborough on 27 November and met the deputy director, the chair of the union committee, members of the Independent Monitoring Board, the deputy controller and the prison's two family liaison officers. The investigator collected copies of the man's prison record and other relevant documents, viewed CCTV from 15 November and interviewed three prisoners. She visited the wing and cell where the man had lived.
11. NHS England (East of England Team) commissioned a clinical reviewer to carry out a clinical review. The investigator and the clinical reviewer jointly interviewed ten members of staff at Peterborough. The investigator also interviewed seven additional members of staff and three Listeners (prisoners trained by the Samaritans to offer confidential peer support). She gave feedback through the prison liaison officer about the preliminary findings of the investigation.
12. The investigator spoke to HM Coroner for Peterborough about the investigation.
13. The investigator asked the man's solicitor for information about a telephone call she had made to the prison. The solicitor said she was unable to provide this information because of client confidentiality.
14. One of our family liaison officers, informed the man's family about the investigation. The family liaison officer and the investigator visited the man's wife on 8 January 2014. The man's wife asked several questions about her husband's time in prison and the investigation which we have answered by letter. The man's wife asked what the man had used as a ligature as she had been told conflicting accounts. We understand that the man used a combination of shoelaces, a laundry bag and torn tracksuit bottoms as a ligature. The man was positioned behind the door, and no one actually saw the ligature as he had placed it because the action of opening the cell door caused it to become dislodged.
15. The man's wife said her father had previously designed prison cell doors and had told her that the man's cell door was not to industry standard. He considered that the gap at the top (where the man had made a ligature point) was too big and there was no anti-ligature strip above the door. Ministry of Justice Estates Directorate have confirmed that the cell doors at Peterborough met the specification at the time the prison was built in 2005. Although there have been subsequent changes to specifications for new build prisons they do not apply retrospectively. The man was not assessed as a risk of suicide and self-harm and there was no reason to hold him in a safer cell with fewer ligature points, although in fact the standard cells at Peterborough have very few.

16. The family liaison officer spoke to the man's ex-wife by telephone and we were subsequently contacted by solicitors representing her (on behalf of her daughter) and the man's parents. We have sent all parties a copy of this report.

HMP PETERBOROUGH

17. HMP Peterborough is a local category B prison privately operated by Sodexo Justice Services. It holds both men and women in separate sides of the prison. The prison has 24 hour healthcare cover. Cambridge and Peterborough NHS Foundation Trust provides a seven-day mental health service.

HM Inspectorate of Prisons

18. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Peterborough in April 2011. Inspectors found that assessment, care in custody and teamwork (ACCT) documents were found to be generally of a high standard with good support from mental health nurses at reviews. Mental health services were assessed as good but there were no day care services for prisoners with mental health problems who found it difficult to cope. All nurses had up to date training in basic life support and emergency equipment was available and checked daily.

Independent Monitoring Board

19. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. The IMB annual report for 2012 – 2013 noted that combining primary and secondary mental health teams into the mental health in-reach team had created some problems. The IMB said that some good work had been done to make staff aware that anyone could refer prisoners to the in-reach team using the alert system but a lack of communication between wing staff and in-reach staff had created some animosity. Training had been offered to help wing staff deal with prisoners with mental health needs. A Sodexo clinical health audit had highlighted other issues relating to communication and records in the in-reach team which had impacted on their management of prisoners with difficult and complex needs.

Previous deaths at Peterborough

20. There has been one other self-inflicted death at Peterborough since 2009. There were no direct similarities with the man's death.

Suicide and self-harm monitoring

21. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the 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. Support for prisoners includes setting a number of significant interactions with them during the day, supplemented by checks on their well-being during the times they are locked in their cell. Part of the ACCT process involves assessing immediate needs and drawing up a care-map to identify the prisoner's most urgent issues and

how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the care-map have been completed, and a review should be held within a week of the ACCT being closed.

Peterborough's alert form protocol

22. In April 2011, the mental health in-reach team became responsible for both primary and secondary mental health care. The alert system was originally a primary care process. Any member of staff can complete an alert form if they have concerns about a prisoner's mental health. Alerts are sent by internal post or email to the in-reach team administrator where they are logged and passed to the duty worker for early screening. Non-urgent alerts are reviewed at the next available weekly team meeting and allocated a slot at the next available clinic. Urgent alerts are allocated immediately. The target for face to face contact for non-urgent alerts is within three weeks of the alert being raised.

KEY EVENTS

20 October 2013 – 28 October 2013

23. The man had no criminal record. In October, the man dropped his daughter off at his ex-wife's home and said they would not see him again. His ex-wife was concerned and called the police. The man was arrested and taken first to Addenbrooke's and then to Fulbourne Hospital under section 136 of the Mental Health Act 1983 (which allows the police to move someone apparently mentally unwell to a place of safety for up to 72 hours). A registrar, a speciality registrar in psychiatry and an approved mental health professional assessed him. The registrar subsequently wrote to the man's GP. He said that the man had threatened to set himself on fire in his car because he was having difficulties in his relationship with his wife.
24. The man told the registrar that he had been having suicidal thoughts since his wife had left him on 14 October. He said that he had researched suicide methods on the internet. The man's wife said that she had found him with a can of petrol in the garage on 13 October and he had told her that he had suicidal thoughts and plans. The man told the registrar that he might have acted on his plan to set himself on fire, though he had not taken any steps to do so at the time he had been arrested. The man said he felt hopeless, was sleeping poorly and had previously had suicidal thoughts and plans when he had separated from his ex-wife. He had not acted on these at the time because he had distracted himself with sports and work and then met his current wife. The man told the registrar that since he had got to the hospital, he had spoken to his wife and they had agreed to continue their relationship. He said he would be safe as long as he had her support.
25. The registrar concluded that the man had symptoms of depression, rigid personality traits and maladaptive coping strategies, particularly when dealing with relationships. He discharged the man and advised that he should see his GP for a follow up. He said the man did not want anti-depressant medication but would consider having psychological therapy. The registrar strongly recommended that the man undergo therapy and asked the GP to consider referring him to IAPT (improving access to psychological therapies – an NHS programme treating people with depression and anxiety disorders) for cognitive behavioural therapy (CBT).
26. On 22 October, the man's GP, made an urgent referral for an outpatient assessment by the local community mental health team on 31 October. She saw the man with his mother-in-law on 24 October. He appeared depressed but refused anti-depressants. The man saw another GP on 25 October. He said was concerned about going to his in-laws at the weekend, but said that he did not feel suicidal.
27. On Sunday 27 October, the man made several telephone calls from a car park in Norfolk, including to Urgent Care Cambridgeshire (an out of hours service for immediate life threatening conditions). He told the doctor that his wife was away from home, he was unable to face the world and he felt

suicidal. He also called Cambridge Emergency Duty Team (an out of hours mental health service) who called the police. The man was found by Norfolk Police and told them he felt like killing himself. He was arrested and taken to Hellesdon Hospital, Norwich, under section 136 of the Mental Health Act 1983.

28. Two doctors and an approved mental health worker assessed the man. He told them he had emotional difficulties dating back to his first marriage that had been exacerbated by a number of bereavements, including the death of his best friend. The man appeared anxious and spoke rapidly with convoluted responses to questions. He said that he had no serious intention of harming himself and that his recent behaviours were an attempt to re-engage his wife in their relationship. The doctors concluded that the man was not suffering from a mental disorder within the meaning of the Mental Health Act. They noted that he said that he had no serious intention of harming himself and that, when he had been detained under section 136, he had alerted others to the fact he was feeling low. They noted that he had an appointment with his GP the next day and one with community mental health services on 31 October, and discharged him from the section 136 detention.
29. The man's GP spoke to the man by telephone on 28 October, but he ended the call as he said he was expecting a call from his wife. According to police records, the man subsequently set fire to the stairs in their house during a video call to his wife. The man's wife said she was in the house at the time and that the man was speaking to his father-in-law on the telephone. The fire set by the man caused an estimated ten thousand pounds damage and was put out by the fire brigade.
30. A police doctor, saw the man the same day, at Parkside Police Station, Cambridge. The doctor noted that he was anxious, very emotional but cooperative, maintained good eye contact and his speech was normal in tone, rate and volume. The doctor said the man was subjectively low in mood but objectively normal in mood. He denied suicidal and homicidal thoughts and was very regretful. He said the man's risk of self-harm was "raised" and recommended that he should be kept under constant observation at the police station.

HMP Peterborough

31. The man appeared at Cambridge Magistrates' Court on 29 October and was remanded to HMP Peterborough. The police noted on his person escort record (PER – a document which accompanies prisoners between police stations, the courts and prison and which lists relevant risk factors) "Attempted to set self on fire" in the suicide/self harm section of the PER and the mental health section indicated "awaiting assessment – stated on 28 October". The court custody staff noted on the PER that the man was "in a very emotional mood, crying. SASH [suicide and self-harm] form completed due to this and self-harm marker on PER. Checked five times an hour. Told staff who checked on him he was feeling down."

32. A prison custody officer, PCO A, noted on the suicide and self-harm warning form that the man seemed very depressed and had harmed himself within the previous month. He wrote, "The man very emotional, crying, low mood. Form opened as a precaution as the man attempted to set himself on fire on 28/10/2013." The PCO recorded that he had contacted a senior custody officer at HMP Peterborough.
33. The man arrived at HMP Peterborough at about 4.30pm. Healthcare Assistant A, completed the man's reception health screen. The man told her he had an outstanding hospital appointment at 11.15am on 31 October but did not say what the appointment was for. He gave her his GP's details. The man said he had not been in prison before and had no psychiatric nurse or care worker in the community.
34. Healthcare Assistant, A, told the investigator that the man was, at first, very quiet and contained. She said that she knew from the suicide and self-harm warning form that the man had attempted to set himself on fire and this, together with his quiet demeanour, indicated to her that he was potentially at high risk. She did not have any other information apart from the warning form. She said that she had explained the ACCT process (suicide and self-harm prevention procedures) to the man. She told him that ACCT was a "two-edged sword". It was a protective measure and could be a support, but that someone would come and see him every 20 minutes and it would not be conducive to a good night's sleep. On the other hand, if he wanted someone to talk to he might welcome the intervention. She said that ACCT works most successfully if the prisoner consents to one being opened. She told the man that, with the information on the warning form, she would have to have a really good reason not to open an ACCT. She explained that a member of staff would check him every hour as a first night prisoner and in the morning another nurse and a doctor would see him.
35. Healthcare Assistant, A, said that the man then began to talk more openly to her. She said she had spent 15 minutes with him and told the investigator she felt she had explored his risk of suicide and self-harm. The man told her he really wanted a good night's sleep. He assured her he would be safe overnight and that he would like to see the GP in the morning. She said she told him that she would trust him to remain safe overnight and to see what prison was really like.
36. PCO B completed the man's reception interview. The PCO told the investigator that the man's PER stated he had attempted to set himself on fire, although he did not see the man's suicide and self-harm warning form, which should have been with the PER. (It was kept in his medical record.) He said he asked the man about the entry in the suicide and self-harm section on his PER which referred to him attempting to set himself on fire. The man explained that he had been in the middle of a video call with his wife. He said he had wanted to get her attention and had splashed petrol on the floor for effect. He told the PCO that he had not meant to set a fire and that he had put it out immediately. The man said he had not intended to set himself on fire and had just wanted to get his wife to speak to him. The man told him

that, now he was in prison, his mind was clearer. He had spoken to his wife and now felt calmer. He said he had no intention of harming himself, then or now. The man's wife told the investigator that she had not had any contact with the man during his time in custody.

37. PCO B said the man's main concern appeared to be that he would get a life sentence. The PCO said he tried to reassure the man that this was unlikely if events had been how he had described. The man said he might need someone to talk to and the PCO explained about Listeners (prisoners trained by the Samaritans to offer confidential peer support) and the Samaritans phone (a cordless telephone which prisoners can use in their cells to talk directly to the Samaritans). He told the man that he could ring his cell bell and talk to night staff if he needed to and explained that all new prisoners were checked hourly on their first night. The PCO described the man as quite chatty, not upset and not in a low mood.
38. PCO B said that when he saw the information on the man's PER he automatically thought of opening an ACCT. However, after speaking to the man, he changed his mind. He said he was reassured by the man's explanation of his offence and did not consider that the man came across as vulnerable, even though it was his first time in prison. He said the man just seemed to need someone to talk to. He said he explained the ACCT process to the man and told him he could ask to be put on ACCT if he considered it necessary.
39. After the interview Healthcare Assistant A and PCO B discussed the man and agreed they did not need to open an ACCT. They told the investigator that they work as a team in reception and discuss whether to open ACCTs.
40. W1 landing of Houseblock 3 is the first night and induction landing at Peterborough. If there are no spaces on W1, new prisoners are allocated cells on X1 landing, which is usually used for new prisoners requiring detoxification. All new prisoners at Peterborough are checked once every hour on their first night. As well as a night operational support officer, X1 landing also has a healthcare assistant on duty. The man was allocated to X1, cell number 13, because W1 was full.
41. OSG A was the night operational support officer on duty on X1 landing during the man's first week in Peterborough. She told the investigator that she had explained to him that she would check him every hour on the first night. She said that the man told her about the charges he was facing and said that he should not be in prison and needed to speak to his MP. The OSG said that the man talked to her often about these issues for his first three nights and then appeared to settle down. The man's first night observation sheet records that he stayed up writing a letter before going to sleep at about 1.30am. The OSG told the investigator he spent most of his nights reading or writing letters. She said he was polite and charming and happy to speak to her. Nothing about his behaviour had caused her any concern for his welfare.

42. Healthcare assistant, B, was on duty when the man arrived on X1. She told the investigator that he was “teary” and told her he needed to speak to his MP because he was innocent. She said the man seemed calmer after the first few days. He was always keen to talk and nothing about his presentation caused her to be concerned about his state of mind.
43. At 10.38am on 30 October, Nurse A carried out a secondary health screen, a more in depth assessment than at reception when the prisoner is weighed and general observations such as pulse and blood pressure are taken. The prisoner’s GP notes are requested and a risk assessment is completed to determine whether he can keep any medication in his cell. The nurse concluded that the man could keep his medication for a fungal nail infection. The assessment includes standard questions about suicide and self-harm. The nurse told the investigator that the man told her that he missed his wife and he wanted her to come home. He said he had not meant to start the fire at his home. She said the man spoke a lot and very quickly. He appeared agitated, but not vulnerable or more anxious than most people are in prison. She saw nothing in his presentation that caused her to consider opening an ACCT document or refer him to the mental health team. He did not say that he had been due to have an appointment with the community mental health team the next day.
44. At 2.30pm on 30 October, PCO C from the prison’s safer custody team spoke to the man in his cell. The PCO told the investigator that, within 48 hours of their arrival, she introduces herself to every prisoner who comes to Peterborough for the first time or who has self-harm markers on their PER. She explains the role of the safer custody team and tries to reassure the prisoner that help is available if they need it. She gives each prisoner a leaflet about the safer custody team and explains the support they can offer. She told the investigator she does not ask directly about any suicide or self-harm information on the prisoner’s PER, but waits to see if they volunteer information. She does not regard it as risk assessment, but gauges how prisoners are feeling and checks with wing staff to see if there are any concerns.
45. PCO C said the man was sitting writing at his desk when she went to see him and talked to her incessantly for ten or 15 minutes. He told her that he should not be in prison that he was due back in court and hoped to get bail. He said that as he owned his own business he was losing money in prison. He told her that he had been writing down things that were wrong in the prison. The PCO said the man appeared annoyed about his situation but did not appear anxious or low. He thought that the description of his offence as having attempted to set himself on fire was “ridiculous” and that it was a misunderstanding with his wife. The PCO said nothing in their meeting gave her cause for concern about the man’s welfare.
46. The Chaplain’s log for 30 October records that the duty chaplain spoke to the man spoke for 30 minutes. The entry reads, “Seen by duty chaplain for 30 mins. First time in prison. Quite scared and confused.”

47. The man's GP notes were faxed to the prison the same day. All GP notes are read by one of the prison GPs before being put into each prisoner's paper medical record. Prison doctor A read the man's GP notes that afternoon. He noted that the man had been the subject of a section 136 detention after suicidal thoughts on 20 October (the assessment made at Hellesdon Hospital on 27 October had not been passed to the man's GP at this stage) and as a result reversed Nurse A's decision that he should be allowed to keep his medication with him. The prison doctor told the investigator that the man had received a full psychological assessment in hospital on 20 October and that if the psychiatrist had thought there was any imminent risk to his well-being he would not have discharged him.
48. At about 3.00pm on 30 October, the man had an induction session in the prison gym. One of the duty Listeners was present and introduced himself. He said that he and the man then spent three hours 20 minutes talking in the Listener's Suite. The Listener was unable to tell the investigator the substance of their conversation because the undertaking of confidentiality continues after death. He said that the man was intelligent and articulate and had no problem talking to him.
49. PCO D told the investigator that he was the officer in charge of X1 when the man was there. He thought he had introduced himself to the man on 30 October. He said the man had told him that he should not be in prison and needed to be out the following week because he was expecting a delivery of materials for his business. The man said he had been accused of trying to burn his house down but the reality was he had had an argument with his wife, it was a very minor fire and he had put it out straight away. The PCO said he gave the man a couple of letter sheets and advised him to write to his solicitor. The PCO said he was aware it was the man's first time in prison and had given him information about how to collect his medication.
50. PCO D said the man seemed to settle down after a couple of days and stopped saying that he should not be in prison. He started mixing with other prisoners and the PCO said he saw him laughing and joking with them. PCO D said the man did not seem anxious and gave him no cause for concern during his time on X1. PCO D had read through the man's wing file but he did not know that the man had arrived with a suicide and self-harm warning form or what had been written about his risk on his person escort record and he did not know that the man was having marital problems. He said that the PER and the suicide and self-harm warning form should have been in the man's wing file but were not.
51. On 1 November, The man completed an application to see a member of the IMB. Applications are collected each week from the wing IMB boxes and passed to members to answer. The man headed his application "urgent". He said he had made numerous polite requests to staff for many different things, ranging from "issues that have got me in here in the first place, where as it could have been avoided" to what he felt were serious issues about his treatment in prison. The man said prison procedures were being violated and this was causing him additional stress and depression and damaging his case

and life outside prison. He said he would welcome a meeting with the residential manager or prison director.

52. The man also completed a complaint form on 1 November in which he said that he had made numerous verbal requests for help but had not received a response. He said he was feeling very low physically and mentally and his emotions were making him ill. The man said he was suffering medically but no one was checking him, although he had not asked to see a doctor. He said he was not eating and had spent all day alone in his cell trying to escape the noise. He said he had put in a request to see a member of the IMB but had not received a response. The X1 wing observation book for 1 November shows that the man refused lunch and dinner.
53. On Saturday 2 November, Senior Officer (SO) A said that a member of staff (he could not recall who) was concerned that the man was not settling well and asked him to speak to him. The SO said that he had PCO D, to join him as he was a trained ACCT assessor. They found the man in the cell next door watching TV with three or four other prisoners. SO A said the man appeared calm and was chatting happily to the others.
54. SO A and PCO D spoke to the man alone. He told them he was concerned about his business. He was due in court on 5 November and was hoping to get bail. SO A said the man appeared to be fine and was happy to talk about himself. The officers did not have any concerns about the man and saw no reason to open an ACCT. Later the same day, SO A said he saw Nurse B on the wing and, as she was a mental health nurse, asked her to go and speak to the man. Later on 2 November, Listener A and Listener B spoke to the man for two hours in his cell.
55. At 10.41pm on 2 November, the man told a night officer that he had cut his finger on a razor blade he had found in his cell. The officer rang Nurse A who advised that the man should make the cut bleed and wash it under running water. The nurse booked him an appointment in the blood-borne virus clinic.
56. On Sunday 3 November, Nurse B went to see the man in his cell, as SO A had requested. At 3.46pm, she wrote on SystmOne (the electronic prison medical record) that she had seen him on the wing, he had signed a consent form to obtain his medical records and that she would contact his GP. (Nurse B does not seem to have been aware that the man's GP records had already arrived.) Nurse B was the duty mental health in-reach nurse that weekend and part of the role is to provide advice to wing staff, including whether to complete mental health alert forms. The duty nurse is not supposed to visit prisoners on the wings unless they have already been taken on by the mental health team and have a scheduled appointment. (Nurse B's contact with the man has therefore been the subject of a disciplinary investigation by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT, the provider of mental health services to the prison) and we have not interviewed her.)

57. Nurse B told the CPFT investigation that she knew she was not supposed to visit prisoners on the wings at weekends, but had gone to see the man in the interests of maintaining good working relations with wing staff. She said her proper course of action should have been to advise wing staff to complete an alert form or, if the matter was urgent, to contact the prison GP. Her entry in the duty worker book shows that she advised SO A to complete an alert form. In her notes of the visit, also in the duty worker book, she noted that the man was anxious and wanted someone to talk to. He mentioned the loss of a friend and said he was anxious about contact with his wife. Nurse B wrote that the man's account was somewhat disjointed. He had told her that he was due to appear in court on 5 November.
58. Nurse B said she planned to track the man to see if he returned to prison after court. If he returned, she planned to see him again and, if not, she planned to contact his GP and advise them of her concerns. The nurse said she had completed an alert form on behalf of wing staff and obtained the man's consent to contact his GP. There is no evidence that she or any of her colleagues checked whether the man came back from court and Nurse B said that she was unsure where responsibility for tracking the man lay. The alert form and the consent form Nurse B said she completed have not been found. Nurse B said she told the morning meeting on Monday 4 November about her visit to the man but the minutes simply record, "feedback from wkend (sic) given" and no actions appear to have resulted.
59. On the night of Sunday 3 November, Healthcare Assistant B wrote in the wing observation book "Please can someone read note from the man X1/13 and someone speak to him. Unable to do confidential chat in night state." We do not know what note she was referring to but on 4 November a residential manager, visited the man in response to the healthcare assistant's note and his complaint form of 1 November. She wrote in the reply box that she had spoken to the man and arranged for a wing officer to give him a towel, razor and toiletries until he received his prison shop order. The man told her that he was eating food from the servery, but did not like some of it. She promised to review his location as he was still on X1. The residential manager said that the man was in prison for the first time and was finding it a big adjustment. He appeared physically and mentally well and did not raise any other issues with her. He told her he was seeing healthcare staff. The man was moved to cell 47 on W1, the prison's induction unit, the same day.
60. The man wrote another complaint form dated 4 November. He said he had two serious health worries. On 2 November he had cut his finger on a discarded razor blade and he asked why he was on a wing for drug users. He said he had been given a blood test, but would have to wait until February for the results. On 3 November, he said he had caught another prisoner in his cell who had asked him not to tell staff. The man said he was now concerned that something had been hidden in his cell. The man qualified his complaint to say that he had since been visited by 'residential manager' who had been helpful (we believe this to refer to residential manager) and had also moved to a cell on W1 where he hoped things would not be so bad. The man wrote an application to the IMB the same day in exactly the same terms, including the

riders that the residential manager had later been to see him and arranged a move for him.

61. The man appeared at Cambridge Crown Court on 5 November. His PER recorded “safer custody marker” in the suicide and self-harm box under relevant risks. Nurse C saw him before he left for court, she recorded that the man had told her he that had not had his medication for eight or nine days and when he had attended the medication hatch he was told he had already received it. The man had told the nurse that he hoped to be released from court, but he was remanded in custody again. Healthcare Assistant A wrote in SystmOne that he raised no issues when he returned, but she told the investigator that she could not remember speaking to him.
62. Health Care Assistant C on night duty on X1 landing between 4 and 10 November and, at about 1.00am on 6 November, he responded to the man ringing his cell bell on W1. The man wanted to speak to a Listener, but the duty Listener was busy. The health care assistant offered him the Samaritans phone but the man asked him to talk to him through the door. The man told him that the fire in his home had been an accident. He said he had been very angry because he was apart from his wife. The man also said he had no access to his daughter. He said he was very busy at work and talked about going back to work when he got out of prison. He asked the health care assistant what he thought of the idea of him writing a letter of apology to the fire service. The health care assistant said he thought it was a good idea.
63. Later that night, the man gave Health Care Assistant C a letter he had written to the fire service. In the letter, he apologised for his actions, and said that he struggled sometimes to differentiate between loneliness, abandonment, loss and grief. He said that he had destroyed his life, work, contact with his daughter and possibly with his wife. He said that he hoped there was a way forward before he crumbled in prison, where he did not fit in, cried every day and could not stop punishing himself. He offered to do part-time work as reparation for the incident and said he would like to hear from anyone at the fire station who had suffered loss or trauma or who understood good coping mechanisms.
64. Healthcare Assistant C told the investigator that he became worried about the man’s mental health after reading his letter and speaking with him. He thought that the man presented like someone with mental health problems who needed help. He told the man that he was going to refer him to the mental health team. The health care assistant, who was not trained in ACCT procedures, said that the man seemed okay with this. He said normally he would write an entry on SystmOne and send an email to the mental health team because this resulted in more immediate action than raising an alert form. However, he had forgotten his SystmOne password so he asked the nurse on duty, Nurse D, to see the man so she could refer him to the mental health team.
65. Nurse D told the investigator that she had become aware of the man during the night duty that week because he always had his light on and liked to talk

to the officer and the healthcare assistant on duty at night. She remembered that he used to sit at his desk writing. On 6 November, she read the man's letter and spoke to him. He told her that he should not be in prison and talked about his wife. The nurse said the man appeared fixated on both subjects and kept going over the same things. She described him as calm but persistent. His letter to the fire service caused her to question his mental stability, especially given the nature of his charges. When she returned to her office she checked the man's clinical notes and noticed the information from his GP and his history of threatening to harm himself.

66. Nurse D told the investigator that she thought that the man should be assessed by a member of the mental health in-reach team as soon as possible, but she had not been worried that he was in imminent danger of suicide or self-harm. At the time she had not been trained in ACCT procedures, but had received ACCT training since and did not consider, even with that training, that she would have opened an ACCT that night. She said that the man appeared slightly manic but stable and she knew he was talking frequently to the staff on duty. The nurse noted on the man's SystemOne record that night staff on his wing had asked her to refer the man to the mental health team. She said that he was struggling in the prison environment and to come to terms with the charges he was in prison for. She said she would enclose the letter he had written to the fire service with her referral.
67. Nurse D also completed an alert form and that night staff had become concerned about the man's behaviour and a letter he had written to the fire service. She said this could be described as bizarre in the context of his alleged offence. In the section on other symptoms suggestive on mental illness, the nurse wrote, "Attempted to set fire to himself and home." The nurse left the letter the man had written on the nursing team leader's desk. The nurse also sent an email to the mental health in-reach team telling them she had completed an alert form and that she had left the man's letter on the nursing team leader's desk. The nurse told the investigator that she had not wanted the man's alert form to be lost in a pile and her intention was that he should be assessed as soon as possible.
68. Nurse D saw the man the next night, 7 November, as the cut on his finger was red and swollen. She told the investigator that she assumed his referral to the mental health in-reach team was underway at this stage. The nurse finished her night duties on 10 November. She had received no response to the email she had sent to the mental health in-reach team on 6 November. The man's alert form was not treated urgently and he was not seen by a member of the mental health team before his death.
69. On the night of 7 November, The man gave Health Care Assistant C a letter to put in the prison post. The Health Care Assistant told the investigator that the letter was addressed to the man himself, which he thought was strange, but he put it in the post anyway. The man's wife, who shares his initial, told the investigator that she had received two letters from the man while he was in prison, although the police had told the prison that he should not be allowed

to contact her. It is possible that this was one of those letters. The man also spoke to Listener B on 7 November for 30 minutes in the Listener's Suite.

70. At 3.30am on 8 November, the man gave Operational Support Officer B a letter written for the attention of the police. According to the man's Mercury intelligence record (prison security record) OSG B read the letter and contacted the night orderly officer who advised him to complete a security information report. In the letter the man apologised for any distress or inconvenience caused by his actions on 28 October and talked at length about his marriage. He said he had been told that his wife did not want to have any contact with him. He said he felt depressed and had no purpose and was worried about his mother. The man asked the police to ask his wife if she was okay and if she still loved him.
71. Later on 8 November, the man had an application to have his wife's name added to his list of approved visitors turned down as the police had stipulated that he should not contact her. The same day he spoke to the duty Listener, for two hours in the Listener's Suite. The duty Listener knew the man before he spoke to him as a Listener and said the man was forthcoming, intelligent and very chatty. He said the man went to the gym regularly to play badminton and he saw him talking to several people there. He did not think the man was reclusive or shy and said he seemed perfectly fine in the gym environment. However, the duty Listener said he did not see the man in the gym after 8 November.
72. On 9 November, PCO E wrote in the man's record that he had completed his induction programme, but he did not seem to be adjusting well to prison. He described the man as very timid and easily upset, was slow to learn the regime and saw a Listener almost every day. PCO E told the investigator that the man was very quiet and polite, but appeared a bit overawed when he arrived on W1 and was sometimes tearful and unwilling to leave his cell. PCO E said officers made efforts to encourage the man to come out of his cell at mealtimes and gradually he began to come out more and started talking to people. PCO E said nothing in the man's demeanour or conversation had given him cause to worry that he was at risk of suicide or self-harm. However, he thought it was possible that more experienced prisoners might take advantage of him so the staff kept an eye on him. PCO E arranged for the man to start working in the gym on 19 November.
73. According to his records, the man made his last telephone call on 9 November at 12.05pm. Prisoners' telephone calls are recorded but, unless someone is being monitored for security reasons, only a random sample is listened to and this call was not listened to while he was alive. In his last call, the man spoke to his mother and told her he was trying to get bail. He said his wife was taking advice from a solicitor about ending their marriage. The man read out an excerpt from a letter from his solicitor which said, "I know you are deeply upset at [his wife's] decisions, you have expressed to me your feelings that your life is not worth living". The man told his mother, "I did say that but I haven't said that I am going to kill myself in here to her, she says that you have previously voiced these feelings to the police and medical

services, of which I have said things like – I'm feeling very low but I'm not going to do anything stupid, the letter then says 'and due to the potential risk of your safety I have contacted the safer custody officer at Peterborough prison'. After this the call cuts off.

74. PCO F, from the safer custody team, told the investigator that she remembered being with prisoners when she was told that a solicitor wanted to talk to her about the man. As she was busy she asked if the call could be taken by the orderly officer in charge of the day to day running of the prison that day. PCO F said that she saw the orderly officer later that day and asked him what the call had been about. He told her not to worry as he had dealt with it. The orderly officer told the investigator that he did not remember taking the call. He said that if he received concerns from solicitors about their clients, he passed their concerns to reception staff so they could talk to the person when they returned from court. The man's solicitor confirmed in a statement provided to the Coroner that she phone the prison on 8 November and spoke to a male officer, who she believed was in the safer custody department. (We believe this was the orderly officer.)
75. Later on 9 November, The man spoke to Listener A and Listener B for an hour in his cell. On 10 November, the man used the Samaritans phone at 6.40pm and 7.15pm. He returned it at 8.30pm. On 11 November, the man was visited by his father and brother. According to the solicitor representing the man's father, during the visit, the police served the man with an order preventing him from having contact with his wife.
76. On 12 November, Residential Manager, responded to the man's second complaint form of 4 November. She said she had spoken to him about both issues. She noted that he had now moved to W1 and had said that he was now receiving appropriate care for his cut finger. She said she had given the man a privacy key for his cell on 4 November (which allows prisoners to secure their cell from others while still allowing staff to enter). She had advised him to tell staff if he found someone in his cell and did not feel able to tell them to leave.
77. The man appeared at Cambridge Crown Court on 13 November. The risk section of the person escort record included "safer custody marker" in the suicide and self-harm section and a marker for "harassment". The man was convicted of committing arson recklessly and was remanded back to the prison for a pre-sentence and a psychiatric report. The man's wife told the investigator that the man had listened to her victim impact statement which would have left him in no doubt that their marriage was over. He also listened to a victim impact statement from his ex-wife in which she said that she did not want his daughter to visit him in prison.
78. Health Care Assistant, A, saw the man in reception on his return to Peterborough. She told the investigator that she automatically sees a newly-sentenced or convicted prisoner returning from court because this constitutes a change in circumstances. She said the man told her that he was not concerned by anything that had happened at court (Health Care Assistant A

did not know about the legal action preventing contact with his ex-wife, the end contact with his daughter while he was in prison, or about the end of his marriage) but wanted her to treat the cut on his finger. She said she explained that she could not do anything to his finger in reception but would book him an appointment for it to be dressed. She said whenever she asked the man a question about court or how he was feeling he just said he was okay and talked about his finger.

79. SO B took the man back to W1 from reception. She told the investigator that he had seemed perfectly happy and asked for some hot water for his flask. She had asked him how it went at court and he had said it was all right. On W1, The man sat and talked to an operational support officer, A, before SO B locked him in his cell for the night.
80. On 14 November, a member of the IMB, visited the man in response to the application he had made on 1 November. (According to the form, the application had been received by the IMB on 8 November.) She wrote on the application form that she had had a long conversation with the man who was very unhappy about his imprisonment and extremely stressed. He had told her he could not be bothered to explain all of his problems but had then spoken to her for 30 minutes until he had to return to his cell for lock up. He told her that he had spoken to some one called "(female name)" (we believe that he meant residential manager). The member of the IMB said that, apart from listening, there did not seem to be much help the IMB could offer the man. The member of the IMB had advised him to see if he could get some counselling as he appeared to have multiple problems. She noted that she had spoken to PCO F, who had told her that the safer custody team was aware of the man and that he was being monitored. The member of the IMB told the investigator that the man had spoken non-stop and quite chaotically. She had been worried about his state of mind so had contacted the safer custody team who had reassured her that they knew about him and were keeping an eye on him.

15 November

81. The night operational support officer, C, on duty on W1 landing on 14/15 November. At 4.09am on 15 November, she checked the man's cell when she was carrying out an early morning roll count. She told the investigator that she had noticed that the man's light was on and his observation flap was open. There was no door card in the door to indicate that a prisoner was in the cell. (OSG D, the operational support officer who had completed the previous roll count at about 10.00pm told the investigator that he could not remember seeing the man at that count.) OSG C saw that his bed was made and then thought that the man was standing by his door. She became concerned that he might have harmed himself and radioed a code blue emergency. Without waiting for assistance to arrive, she broke the seal on her cell key (at night staff on wings do not carry keys for security reasons but have a cell key in a sealed pouch for entering cells in an emergency) and went into the man's cell at 4.10am.
82. OSG C said she initially had difficulty getting into the cell because the man's body was blocking the entrance. The healthcare assistant B arrived and OSG C asked her to bring the emergency response bag. She began to move the man so that other staff could get into the cell. OSG D arrived at 4.11am and used his cut down tool to cut the ligature from the man's neck. They moved the man to the landing where there was more room and OSG D began cardiopulmonary resuscitation (CPR).
83. SO B, the night orderly officer in charge of the prison that night, heard the code blue over the radio and went immediately to W1. The assistant night orderly officer escorted Nurse D, the emergency response nurse. The SO arrived at 4.12am as OSG D was beginning CPR. The SO said that she thought it appeared that the man had been dead for some time. The SO radioed the communications officer to confirm that an ambulance was needed. Nurse D arrived just seconds after the SO and also thought that the man had been dead for some time. She tried to insert an airway to administer oxygen but his jaw was too stiff, suggesting that rigor mortis was present. She attached a defibrillator, but no heart rhythm was detected. Paramedics arrived at 4.24am and began advanced life support treatment but pronounced the man dead at 4.47am.
84. A hot debrief took place for the staff involved that evening and members of the staff care team were present. A critical incident debrief took place on 20 December. All the staff interviewed said that managers had supported them well. On the morning of 15 November, staff on W1 told prisoners individually at their cell doors that the man had died. Listeners were brought to the wing to offer support. A memorial service was held in the prison chapel and was attended by staff and prisoners.
85. A servery worker on W1 and a trusted prisoner with a role to support new prisoners. His cell was two doors away from the man's. He told the investigator that at first the man would not eat prison food or come out of his

cell for meals, so the servery worker had taken his meals to him. The man told him he did not like the food and talked to him about his charges and his wife. The servery worker said the man was out of his depth in prison and had an unrealistic expectation of getting bail. After three or four days the man began to eat. He said he did not think the man was out of control or at risk of harming himself but he thought he was anxious about his environment and his future.

86. The servery worker said he did not think the man was bullied in prison. Part of his role on the wing was to prevent bullying and he kept a close eye on the man because he thought he was a prime candidate for being picked on. The servery worker said the prison officers were very kind to the man, had spent time talking to him and made sure he had been able to talk to Listeners each day. He said W1 and X1 were the most suitable wings in Peterborough for first time or vulnerable prisoners. He said that the officers were distraught after his death.
87. The servery worker said when the man came back from court on 13 November after he had been convicted he was “a different man”. He appeared cheerful and came out for association, which previously he had rarely done. He said the man told him that his wife and his ex-wife both had restraining orders out against him and his solicitor had told him to expect a sentence of between six to eight years. He said he had not thought the man was at risk of suicide but, at the same time, when he heard he had died he was not that shocked. With hindsight, he thought that the man had been cheerful on 13 November because he had already decided to kill himself.
88. Servery worker B also worked on the servery on W1, and lived opposite the man. He said he had only spoken to the man once in any depth when the man had talked about his wife and their relationship problems. He said the man did not appear to understand the reality of his situation and seemed “disconnected”. He too said that the man did not mix much on the wing and did not eat much at first but he thought he was gradually getting used to being there. Servery worker B was also a first time prisoner and said that it had taken him several days to get used to prison life. He thought that the man had had a similar experience. He said that the man appeared different when he came back from court on 13 November as he seemed cheerful, ate a full meal and took part in association.
89. Prisoner A was in the cell next door to the man. They first started talking because they both went to court together on 5 November. The man had told him about his wife and the circumstances of his offence. The prisoner said the man appeared lost in prison and had unrealistic expectations of being granted bail at court. He thought the man was in “a bubble”. He tried to limit his expectations about being released, but had not been worried that the man would harm himself and his death had been a shock.
90. All three of the Listeners interviewed told the investigator they were deeply shocked and surprised by the man’s death.

Writing found in the man's cell

91. The police removed several pieces of writing from the man's cell including letters and a note he wrote on 14/15 November. We understand from interviews that one of these contained an apology to prison staff who would find him dead. At the time of writing none of the notes or letters had been disclosed by the Coroner so we are unable to comment further.

Family liaison

92. The head of the male prison, acted as the prison's family liaison officer. He and a colleague broke the news of the man's death to his wife at her parents' house at 9.45am on 15 November, before going to the man's parents' home to inform them. The prison offered a financial contribution to the man's funeral in line with national guidelines. The man's wife and her father visited the prison to see his cell. The prison also kept in contact with the man's parents and his ex-wife.

Post-mortem

93. A post-mortem examination on 19 November 2013 gave the cause of death as hanging. A toxicology report showed that the man was not under the influence of alcohol or drugs at the time of his death.

ISSUES

Assessing the risk of suicide and self-harm

94. When the man arrived at Peterborough he had a number of factors that indicated he was at raised risk of suicide or self-harm. It was his first time in prison, he had made a recent attempt to set himself on fire, his offence was arson and he arrived with a suicide and self-harm warning form which indicated that he had been tearful and low in mood at court. In addition, although not known to reception staff, his marriage had broken down and he had had recent contact with mental health services. Both the healthcare assistant in reception, and PCO B, individually and then in discussion together, considered opening an ACCT when he arrived but decided against it, after being reassured by talking to the man.
95. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors in comparison to the man's presentation. The man was clearly an intelligent and articulate man and was able to minimise his offence and the state of his relationship with his wife in his conversation with PCO B.
96. We cannot know whether management under ACCT procedures would have changed the outcome, as this cannot guarantee a prisoner's safety if he is determined to take his own life. However, it would have allowed appropriate supportive mechanisms to be put in place to help identify and address causes of distress. The ACCT process would have given staff the opportunity to make a fuller assessment of the man's risk at multidisciplinary reviews. It would have been able to take into account information from his GP which became available the day after he arrived which indicated his recent significant contact with mental health services and that his GP had made an urgent referral to the community mental health team. The disintegration of his personal life would also have become apparent. At the very least some consideration of his risk factors in the round should have resulted in an assessment by the mental health team.
97. Had the man been managed under ACCT procedures, his letter to the fire service of 6 November would have been considered at an ACCT review. We showed the letter to Dr A, the prison GP, when we interviewed him who said that had he read it, he would have opened an ACCT without hesitation because it indicated that the man was ruminating on his situation. Perhaps most significantly, if he had been managed under ACCT procedures, the man would have been formally reviewed after his court appearance on 13 November. Other prisoners who knew him said that the man had lacked

awareness of the reality of his situation. By the time he returned from court on 13 November, it would have been clear to him that his marriage was over and that he was unlikely to see his daughter. He was also not freed on bail as he had hoped and now faced a significant custodial sentence.

98. We are concerned about the perception of the ACCT process among reception staff at Peterborough. Health care assistant A described ACCT as a “double edged sword”, a term she said she used during reception health screens. SO the officer in charge of reception, told the investigator that ACCT could “hinder not help”. Both appeared to think that monitoring under ACCT meant that the prisoner is woken on every check which is not the case and might dissuade a prisoner from disclosing their vulnerability. The staff appeared to indicate that being managed under ACCT procedures was a choice for the prisoner rather than a procedure the prison has a duty to implement to protect and support prisoners at risk of suicide and self-harm. Dr A believed that the ACCT process was almost seen as protection for staff rather than the prisoner. As a result of their own investigation after the man’s death, senior managers at Peterborough organised learning sessions about the ACCT process, particularly targeted at healthcare staff.
99. We asked staff at interview what information would help them identify prisoners who might be at risk of suicide or self-harm. Most replied that the prisoner’s presentation, lack of eye contact, unwillingness to talk and isolation were indicators. Not all staff were aware that some offences were an indicator of raised risk. The prison’s local operating procedure for supporting prisoners at risk of self-harm lists the following information to consider when assessing risk; handover from the escort contractor, reception interviews, information on records, changes in behaviour or demeanour, cleanliness and hygiene, lack of interaction and social isolation. We believe the local guidance should more accurately reflect the risk factors listed in Prison Service Instruction 64/2011 (the national guidance about managing prisoners at risk of self-harm). We make the following recommendation:

The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
 - **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
 - **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**
100. We note that at the time of interview neither health care assistant C nor Nurse D had received ACCT training, although Nurse D has since. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff who have contact with prisoners have received ACCT training.

101. There were other opportunities to open an ACCT after the man arrived in prison. The prison GP read the GP notes and decided not to open an ACCT because the man had undergone a full psychological assessment in hospital on 20 October which had decided not to detain him. When Dr A was told at interview that the man had also been sectioned under 136 of the MHA on 27 October, he said that this would have confirmed his view that the man's risk of suicide had been properly assessed and he was not at risk at that time. While we understand this point of view, the assessments under section 136 took place in the community before the man was remanded into prison, which represented a significant change in his circumstances. Not only was it his first time in custody but as a remand prisoner, the man's situation was subject to further change. The assessments had indicated that the man needed therapy and his GP had referred him urgently to community mental health services for an appointment on 31 October. We consider that this information from the GP notes should have resulted at the very least in a referral to the mental health in-reach team for assessment.
102. Nurse B saw the man on 3 November. She described him as anxious and his speech as disjointed. She did not check SystmOne for information and did not read his GP notes. The man was not tracked by Nurse B as she had indicated would happen. This was another missed opportunity for the man's mental health to be assessed subsequently with all of the information known to the prison at that time. Such an assessment might have picked up on the letter the man wrote to the fire service on 6 November and the concerns that health care assistant C and Nurse B had identified.
103. Nurse B was the only person other than prison GP to read the man's GP notes after she had spoken to him on 6 November and read his letter to the fire service. The nurse was concerned about his mental health rather than his risk of suicide, but at the time had not been trained in ACCT procedures. Her intention was that the man should be assessed by the mental health in-reach team as soon as possible. She made a referral on SystmOne, completed a mental health alert form and to back these up wrote an email direct to the mental health team setting out what she had done. As this was a routine referral, no one from the mental health team had yet assessed the man before his death. Since the man's death, we understand that the alert process has been changed so that the prison GP reviews them weekly in conjunction with the SystmOne record. However we note that the IMB in their most recent annual report were concerned that the alert process had not been properly embedded at Peterborough and there is a need to ensure that all staff fully understand the process and that the mental health team responds appropriately. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff understand how to use the mental health alert process, particularly for urgent concerns, and that the mental health team sees urgent cases promptly.

Emergency response

104. The emergency response was prompt and efficient. The operational support officer on duty, acted commendably quickly, used the correct emergency code and went into the man's cell immediately. The appropriate emergency equipment was available and in working order and an ambulance was called in response to the code.
105. It is evident from the presence of the signs of rigor mortis that the man had been dead for some time when he was discovered. Nurse D told the investigator that she knew CPR would not be possible, but her understanding of the prison protocol was that nurses could not make the decision to stop attempts at resuscitation. However, as a nurse she had been concerned for the dignity of the patient and she believed that the continued attempt to resuscitate the man was contrary to this. The European Resuscitation Guidelines for Resuscitation 2010 state, "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The staff involved were commendably motivated by their duty of care towards The man in attempting resuscitation, but we consider that the staff need guidance and reassurance about when it is acceptable not to perform CPR, to minimise the distress for all involved. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

RECOMMENDATIONS

1. The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:
 - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
 - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
2. The Director and Head of Healthcare should ensure that all staff who have contact with prisoners have received ACCT training.
3. The Director and Head of Healthcare should ensure that all staff understand how to use the mental health alert process, particularly for urgent concerns, and that the mental health team sees urgent cases promptly.
4. The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

ACTION PLAN: Death of a man at HMP Peterborough – 15 November 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p>The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:</p> <p>a) Have a clear understanding of responsibilities and the need to share all relevant information about risk.</p> <p>b) Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.</p> <p>c) Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.</p>	Accepted	<p>The Early Days In Custody (EDIC) Manager will ensure that all operational staff are aware of their responsibilities in identifying, recording and sharing risk information and this responsibility begins when a prisoner is received into prison. Quality Assurance checks will be undertaken by the EDIC manager.</p> <p>ACCT training and refresher training is being provided to all staff, including healthcare and reception staff, and this will be reviewed annually.</p> <p>The prison will reinforce this training at team briefings, by a presentation to be given by the safer custody team to a full staff meeting, by a notice to staff and with information handouts.</p> <p>This will ensure that staff understand the requirement to consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, and open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.</p> <p>The Clinical leads will ensure that all healthcare staff undertaking initial screening and Cell Sharing Risk Assessments will take account of</p>	<p>EDIC Manager 12.09.14</p> <p>Learning & Development (L&D) Manager 12.09.2014</p> <p>Safer Prisons Manager 12.09.14</p> <p>Head of Healthcare 12.09.14</p>	

			known risk factors related to suicide and self harm and ensure that this information is appropriately recorded		
2	The Director and Head of Healthcare should ensure that all staff who have contact with prisoners have received ACCT training.	Accepted	The L&D manager in partnership with the Head of Healthcare will ensure that all new healthcare staff working in the prison will be provided with ACCT training as part of their induction. Existing staff will be scheduled to receive regular refresher sessions.	L&D Manager and Head of Healthcare 12.9.14	
3	The Director and Head of Healthcare should ensure that all staff understand how to use the mental health alert process, particularly for urgent concerns, and that the mental health team sees urgent cases promptly.	Accepted	<p>The Mental Health Inreach Team (MHIT) have reviewed and revised the alert form.</p> <p>The MHIT team have provided a presentation to a full staff meeting regarding the usage of the Alert system.</p> <p>A staff information notice (attached) was published (SIN 016/2014) which was sent out to staff on 30/01/2014 and was contained in the weekly Director's briefing. The notice is available to staff on the shared folder on PCs.</p> <p>Staff have been advised that if they believe a prisoner needs an urgent referral, the alert form should be passed to the GP through the Duty Orderly Officer who will record the referral on the daily briefing sheet. This will ensure that Healthcare and the MHIT are alerted to the urgent need to assess. All urgent Alert forms from the GP's are seen within 24 hours and these are monitored using a tracker system within MHIT.</p> <p>Joint clinical reviews now take place between</p>	Completed	

			<p>GPs, MHIT and HCC managers to ensure that a review is undertaken of any urgent referrals received and what actions have been taken</p> <p>Representatives from the MHIT team now routinely attend the Director's morning meeting to ensure that any urgent concerns are discussed.</p> <p>The Head of Healthcare will undertake reviews to ensure that urgent referrals continue to be identified, prioritised and actioned, in consultation with Cambridgeshire Foundation Trust</p>		
4	The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.	Accepted	In response to a similar recommendation in an earlier report, NOMS undertook to work with NHS England to produce improved guidance for implementation nationally. NOMS undertook to issue this guidance by December 2014. Once guidance is received, NMC assurance provided and training is given to all nursing staff, it will be immediately implemented.	December 2014	