

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man  
at HMP Hewell on 31 December 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 report into the death of a man who was found hanging in his cell at HMP Hewell on 31 December 2013. He was 44 years old. I offer my condolences to his family and friends.

One of my investigators carried out the investigation. NHS Shropshire and Staffordshire reviewed the man's clinical care in prison. The prison cooperated fully with this investigation.

The man was remanded to HMP Birmingham on 2 December and went to HMP Hewell on 5 December, after a nine month suspended sentence was activated. He was also facing further charges. He had a long history of mental health problems and often self-harmed. Despite this background, and an alert about his risk of suicide and self-harm from the court, he was not assessed as at risk when first arrived at Birmingham or Hewell. On 12 December, he self-harmed by cutting his arm and, from this point, was managed and monitored under Prison Service suicide and self-harm prevention procedures at Hewell. His main concerns seemed to have been related to his level of medication for both physical and mental health problems. Healthcare staff reviewed him frequently and he was assessed a number of times by the GP, mental health nurses and a psychiatrist. At 9.00pm on New Years' Eve, a night patrol officer found the man hanged in his cell. After some initial delay, prison staff, and paramedics when they arrived, attempted to resuscitate him but, sadly, this was unsuccessful.

The man had a long history of self-harming behaviour and it is not possible to know whether more effective intervention by prison staff could have prevented his actions on New Year's Eve. He had good access to mental health services at the prison and was being monitored at the time of his death. However, the investigation found deficiencies in the operation of suicide and self-harm prevention procedures at Hewell. Case reviews were poorly planned and managed and did not always involve relevant staff, including healthcare staff, despite his ongoing health problems. I am also concerned that there were delays in responding to him when he was found hanging. While there is no evidence to suggest that this directly contributed to the man's death, in an emergency time is of the essence. The prison needs to ensure that emergency procedures operate as effectively and quickly as possible.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**September 2014**

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## SUMMARY

1. The man was remanded to HMP Birmingham on 2 December 2013 after breaching the terms of a suspended sentence and was charged with other offences. He arrived with a suicide and self-harm warning form from court. His nine months suspended sentence was activated on 5 December and he went from court to HMP Hewell.
2. He had a long history of mental health problems and self-harm. On 12 December, the man made cuts to his arm and staff began Prison Service suicide and self-harm prevention procedures, known as ACCT. He said that he had cut himself because he was agitated and distressed. He cut his arm again on 16 December and continued to be monitored under ACCT procedures. Staff from the prison's mental health team assessed him and a psychiatrist reviewed him on 19 December. The psychiatrist considered that the man was at ongoing risk of self-harm and had experienced thoughts of suicide for most of his life, but he did not consider that he was at imminent risk.
3. He had been on high doses of medication in the community. Doctors reviewed his medication, reduced the dose and changed some of the drugs he had been prescribed. This caused the man a great deal of anxiety. Doctors adjusted the medication again and made efforts to ensure that he received appropriate treatment. He said he needed a gluten-free diet. This was prescribed at first and subsequently stopped. No one checked this with his community GP.
4. At ACCT reviews, the man said he self-harmed to cope with anxiety and pain from a previous foot injury. He sometimes said he had thoughts of suicide but said he had no plans to act on them. On 16 December, he wrote a letter with instructions to his family in the event of his death. The level of monitoring was increased as a result and a nurse requested a mental health assessment. At a case review on 26 December, at which there was no member of healthcare staff present, a supervising officer assessed his risk as low and reduced the frequency of observations at night to one every hour.
5. At 9.00pm on New Year's Eve, a night patrol officer found the man hanging in his cell. He did not go in immediately but waited until the night orderly officer arrived five minutes later. They began to attempt resuscitation until healthcare staff arrived about ten minutes after the alarm had been called. Paramedics arrived at the prison quickly, but there was a twenty-minute delay getting them to the cell as prison gates, which should not have been, were double locked. Paramedics pronounced the man dead at 9.56pm.
6. The investigation has found that, while it would have been difficult to predict the man's actions, the ACCT reviews were poorly managed and, despite his ongoing medication and mental health problems, healthcare staff were often not present. The clinical reviewer concluded that overall the standard of healthcare provided was equivalent to that in the community. Although he had appropriate mental health intervention, we consider that he should have been referred to the mental health team as soon as he arrived at Hewell. The emergency procedures were poor. We make four recommendations about these matters.

## THE INVESTIGATION PROCESS

7. The investigator, issued notices to staff and prisoners at HMP Hewell, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
8. The investigator visited Hewell on 8 January and obtained copies of the man's prison and healthcare records. NHS England, Shropshire and Staffordshire, conducted a review of the man's clinical care at the prison.
9. The investigator and clinical reviewer interviewed 15 members of prison staff. After the interviews, the investigator gave the Governor verbal and written feedback about the initial findings of the investigation.
10. We informed HM Coroner for Worcestershire of the investigation and have sent a copy of the investigation report to him.
11. One of our family liaison officers, contacted the man's family to explain the purpose of the investigation and give them the opportunity to identify any relevant matters for the investigation. His family had the following concerns which we have covered in the investigation:
  - The number of previous deaths at the prison
  - The adequacy of the emergency response.
  - Whether his risk of self-harm had been identified.
  - Whether he had received the correct medication.
  - The condition of his cell and whether it had been tidied for their visit.
12. The man's family received a copy of the draft report. They pointed out some factual inaccuracies and omissions. This report has been amended accordingly. His family also raised a number of issues/questions that do not affect the factual accuracy of this report and have been addressed through separate correspondence.

## **HMP HEWELL**

13. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as a category D open prison and the Blakenhurst site is a category B, local prison. Mr Wright was at the Blakenhurst site which comprises six houseblocks which hold up to 1074 men. Health services are provided by Worcestershire Health and Care NHS Trust.

## **HM Inspectorate of Prisons**

14. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Hewell in November 2012. HMIP identified a number of significant concerns about staff morale, poor practice and cleanliness. They noted that too many prisoners in the local prison shared cells designed for one.
15. Inspectors found that not all PPO recommendations related to previous deaths at the prison had been implemented. Some personal officers had a reasonable knowledge of prisoners, but the frequency of staff entries in prisoners' case notes varied and reflected a lack of engagement. Inspectors found that the range of health services to be generally good and inpatients in the healthcare unit were positive about their treatment. Mental health and pharmacy services were assessed as satisfactory.

## **Independent Monitoring Board**

16. 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 most recently published IMB annual report for 2012 noted that the number of incidents of self-harm had decreased slightly. The IMB considered that safer custody meetings were thorough and a new safer custody policy provided clear guidance for staff.

## **Previous deaths at Hewell**

17. There were three self-inflicted deaths at Hewell during 2013, including this. One previous investigation found similar issues to those found in this investigation in relation to the management of ACCT procedures.

## **Assessment, care in custody and teamwork (ACCT) procedures**

18. 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. Checks should not be carried out at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap 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 caremap have been completed.

## KEY EVENTS

19. On 2 December 2013, the man breached the terms of a suspended sentence. He was charged with further offences and remanded to HMP Birmingham. On 5 December, his nine months suspended prison sentence was activated and he was remanded until 4 March 2014 on charges of possession of a firearm and theft.
20. Court staff completed a suicide and self-harm warning form, which escort officers gave to reception staff at Birmingham. He told reception staff that he had no current thoughts of suicide or self-harm, but said he was a member of a local gang and believed he might be at risk from rival gang members in the prison. Staff noted these concerns.
21. A nurse completed an initial health screen and recorded that the man was lactose and gluten intolerant and was taking pain relief medication (codeine phosphate) for an ongoing foot injury problem for which he was awaiting corrective surgery. He said that he suffered from manic depression, anxiety and had been diagnosed with post-traumatic stress disorder (PTSD) and had been prescribed fluoxetine, diazepam and tamazepam for these problems. The nurse referred him for a first night mental health assessment and to the GP to review his medication. She recorded that he said he had no thoughts or intentions of suicide or self-harm.
22. Because of the suicide and self-harm warning form, A mental health nurse, carried out a mental health assessment. The nurse recorded that the man had not engaged with a mental health team in the community, which he said was due to him being in and out of prison. He spoke about his childhood, how he found it difficult to mix with other people and said that he was easily led astray. He was concerned about getting the correct medication and diet. The nurse referred him to the primary care mental health team for further assessment.
23. A prison GP then discussed the man's medication with him. The GP recorded that he appeared to be on high doses of benzodiazepine medication and questioned why he was taking codeine. He noted his history of self-harm and that he was therefore unsuitable to keep medication in his possession.
24. The next day, the man attended a prison well-man clinic. A community psychiatric nurse, carried out a more in-depth mental health assessment. She recorded that the man said that he had been diagnosed with various disorders in the last 20 years and had been sectioned under the Mental Health Act three times because of substance misuse problems. He said that he had not used illicit drugs in the previous year as he was subject to a court order requiring him to have regular drug tests. The nurse recorded that the man complained that he had not received all the medications he had been prescribed in the community. She explained that not all types of medication were available in prison and that the GP would decide what he needed. The man said he was agitated, but the nurse recorded that there was no evidence of this during her assessment. He said he had missed opportunities for community mental health treatment as he had frequently been in prison. He said that he had attempted to hang himself in the past, but The nurse recorded that during her assessment she saw no evidence of low mood or an intention to self-harm.

The nurse booked an appointment for the man to be seen by a psychiatrist, the next day.

25. The man told the psychiatrist that he was unhappy that his fluoxetine dosage had been reduced from 40mg to 20mg, and that he was feeling agitated and nervous. He also said that he was not being given the correct diet, which was adding to his anxiety. He showed the psychiatrist numerous scars on both his hands, which he said, were results of self-inflicted cuts he had made during the last 10 years whenever he felt stressed or frustrated. He said that he had no current thoughts of self-harm. The psychiatrist recorded that, due to his history, the man presented a high risk of cutting himself but there were no immediate risks. He prescribed a week's course of medication to help him sleep and increased the fluoxetine to 40mg in line with his original prescription. He noted that the primary mental health care team should follow up with him in a week.
26. On 5 December, the man appeared at Birmingham Crown Court. He was sentenced to nine months imprisonment and remanded on further charges. After his court appearance, he went to HMP Hewell.

### **HMP Hewell**

27. A mental health nurse, completed an initial health screen when the man arrived at Hewell. The man told him that he had been at Hewell in February 2013 on a previous sentence. The nurse noted the issues, which had been raised at Birmingham about his medication, ongoing medical issues and mental health history, and then referred him to a prison GP.
28. The GP recorded that the man had an old injury to his right foot and was taking antibiotics for a tooth abscess. He reviewed the man's medication and recorded that they could all be reissued. The man said that he needed an increased dose of codeine and the GP recorded that this would need to be reviewed.
29. Reception staff completed a cell sharing risk assessment and noted that when he was previously at Hewell and at Birmingham, the man had been considered as high risk because of gang rivalries, so could not share a cell. He was assessed as high risk again, to be reviewed every 28 days. As there were no other single cells available, he spent the first night in the segregation unit before he moved to a residential wing the next day.
30. On 6 December, a prison GP, reviewed the man's medication and noted that he had been prescribed codeine for pain relief at Birmingham. Codeine is not used at Hewell so the GP asked the pharmacy to prescribe a suitable alternative medication.
31. On 7 December, the man told wing staff that he had not been given the correct doses of medication. He said that he should have been getting the same levels as he had received at Birmingham. An officer telephoned the healthcare centre and was told that they were aware of his concerns about his medication, which were being looked into. The man told wing staff that he had mental health problems and a personality disorder, but had not yet seen any mental health staff. A wing officer recorded that this would be followed up but there is no record that this was done.

32. Because of his continued concerns about his medication, A prison GP, assessed the man on 11 December. The GP recorded that he had been prescribed 30mg diazepam daily at Birmingham, which had been reduced to 5mg in the morning and 10mg at night. The man told the GP that this was making him feel agitated and low. He said that he had started to have suicidal thoughts, but denied any intent to carry them out. The GP noted that he was a 'known self-harmer.' The man also requested codeine for the pain in his right foot. The doctor could see that his foot had been badly injured and would be causing him severe pain. She told him that codeine was not used at Hewell but that an alternative could be prescribed. The man told the GP that he had previously been prescribed tramadol instead of codeine but this did not agree with him and had had morphine in the past. The GP decided to prescribe oramorph for the pain and recorded that the diazepam should be maintained at the original dose prescribed at Birmingham, of 30mg daily.
33. The GP told the investigator that as well as his diazepam, the man had been mostly concerned about getting a gluten-free diet and said this could be confirmed with his community doctor. The GP said that there was some information in his records that he had previously been having a gluten-free diet. As this seemed to be causing him some anxiety she initially prescribed some gluten-free products even though there was nothing on the summary from his community GP to say that he needed one. (Subsequently, on 13 December the pharmacist queried this, as there was no evidence from his GP records that he needed a gluten-free diet and he would need a blood test to establish this. The doctor suspended the prescription for gluten-free products on 16 December and booked him for tests to establish if he had coeliac disease.)
34. The GP did not pass on to other staff what he had said about having suicidal thoughts, as he had said he had no intention to put them into effect and she had no other concerns about his presentation. She believed that his main concerns were about his physical health and, if she could try to resolve these issues, he would feel better. The GP said that she discussed all the medications that he had been prescribed by his community GP and while not all were available at Hewell, she said that they agreed a medication regime and the man appeared much happier at the end of the appointment.
35. On 12 December, the man pressed his cell call bell at 1.10pm, and said that he had made cuts to his arm. A nurse recorded that he had made several superficial cuts to his lower and upper left arm, which she cleaned and dressed. An ACCT document was opened and it was agreed that he should be observed at least once each hour for the rest of the night.
36. On 13 December, a safer custody officer carried out an ACCT assessment and noted that the man was unhappy about being in prison again. He was frustrated, as he believed that that he would not be able to move to another prison because of the medication he was currently taking. He said that he had harmed himself out of continued agitation and frustration and used self-harm as a way of managing his feelings. He told the officer that he had technically died twice before because of attempted hanging and blood loss and that his last serious suicide attempt had been in April 2013. He said he was receiving medication for his mental health problems but doctors had recently reduced the dosage. The man said that he felt as though he had lost everything he had

built up and frequently thought about suicide, but would not disclose any plans for carrying this out. As he was in prison, he said that he felt detached from his large family.

37. The officer recorded that the man would be referred to the mental health team, although he was sceptical about the help that they would provide. The officer told the investigator that she did not make the referral but expected this to be done by the Supervising Officer (SO) chairing the first ACCT case review. She said that if it had been urgent she would have done it herself at the time of the assessment.
38. After the ACCT assessment, a supervising officer chaired the first case review which the safer custody officer, a custodial manager and the unit manager attended. They discussed the assessment and the supervising officer recorded that the man did not appear in crisis at the time. He later explained to the investigator that the man was known to be a prolific self-harmer who self-harmed to relieve stress and it appeared to him that he had self-harmed because of stress the day before. The review agreed that he should be observed twice an hour both during the day and at night and assessed his risk of further self-harm as low.
39. Although healthcare attendance is a mandatory requirement of the ACCT procedures, the supervising officer told the investigator that he could not remember whether he had invited any healthcare staff to attend the review. The case review page of the ACCT document has a box which states 'If evidence of mental health problems, current self-harm or high risk, refer for mental health assessment and care as per protocols and with consideration to the level of risk.' The supervising officer told the investigator that he was aware of the instruction but he believed that the man was already known to the mental health team and therefore he did not make a further referral. He said that the review had assessed the man as at low risk because they had dealt with the main issues that had caused him concern, but they kept the ACCT open because of his history and the possibility he would harm himself again.
40. An ACCT caremap is expected to be completed at the ACCT first case review with detailed time-bound actions aimed at reducing the risk posed by the prisoner. The case manager should review the caremap and update it as required at every future case review. The safer custody officer told the investigator that usually the supervising officer would complete the caremap, but as she was at the review and there had been previous problems with caremaps not being completed at Hewell, she decided to do it herself. She could not recall whether she had shown the caremap to the sup[er]vising officer and was surprised that she had not included a mental health referral as an action. The caremap indicated that the main issues needing to be addressed were the man's medication as he felt he was not being prescribed the correct doses; his custody dates, which he felt were incorrect; and the fact that he was waiting to get some telephone numbers from his mobile telephone, which was with his stored property in reception.
41. Over the next two days there were regular observations recorded in the ACCT document. On 14 December, a note in his medical record indicated that the man had declined his fluoxetine medication and told a nurse that he did not want to be happy. The nurse advised him that he should not stop taking his

medication suddenly and that the mental health team would be informed. There is no record that this was followed up or recorded in the ACCT document.

42. During the early hours of 16 December, a night patrol officer informed, the night manager, that the man had passed him a letter addressed to his father, which gave instructions about what he wanted to happen in the event of his death. The night manager went to speak to the man who told her that he did not intend to take his own life, but he was a creative person and needed to explain things to his father. The night manager noted that he had denied any plans to harm himself but she felt uneasy about some of the things he had said to her, including that if he wanted to take his life, he could be dead within four minutes. The night manager increased the frequency of the man's observations to five an hour and passed on her concerns to the duty nurse. Although she did not go to see him, the duty nurse completed a mental health Threshold Assessment Grid (TAG) form based on what the night manager had told her and referred the man to the mental health team.
43. At 6.30pm on the evening of 16 December, the wing manager, spoke to the man who had refused his medication again. He did not suggest he intended to harm himself but the wing manager noted that the frequency of ACCT observations had been increased the night before and in view of his refusal to take medication maintained his level of observations at five an hour throughout the night.
44. At 9.20pm that evening, an officer carrying out an ACCT check found that the man had cut his arm. The duty nurse went to his cell but the man refused medical help. He told the nurse that he was a first-aider and could deal with the cut himself. He said that he had cut himself as a diversion from the pain he was suffering with his foot. The duty nurse said that when she had talked to the man he was 'quite jovial' and she had no immediate concerns about him being in a single cell or his general wellbeing.
45. The next morning, 17 December, because of his further act of self-harm, a supervising officer held an ACCT case review attended by a mental health nurse and wing officer. The supervising officer told the investigator that he had never met the man before the review, so he had arranged for a wing officer, who knew him well, to attend. He had asked a mental health nurse because of the man's mental health issues and his concerns about medication. The supervising officer said he was aware of the letter the man had written the night before, as it was noted in the ACCT document and in the unit observation book.
46. At the review, the man said that his main concern was his medication dosage and the mental health nurse agreed to contact his community GP to check this. He said that the man appeared satisfied with that. The supervising officer said they discussed whether the man needed constant supervision but decided this was not necessary. As he was in a single cell, the frequency of observations was kept at five times an hour at night but reduced to three an hour during the day. His risk of further self-harm was assessed as raised. The supervising officer told the investigator that they agreed to hold a review the next day, after the man had seen the doctor, and the mental health nurse would be able to update him on the medication issue.

47. The mental health nurse recorded in the man's medical notes that he had an extensive history of deliberate self-harm, primarily by cutting or overdose. He recorded that he had not wanted him to attend the ACCT review at first, as he was unhappy with his treatment by healthcare staff. The mental health nurse recorded that the man had said that his issue was solely about medication and the nurse had advised him that an appointment had been arranged with the GP to discuss this. He noted that he had said that he understood that some medications that he had been prescribed were not available at Hewell because they had been misused in the past. He recorded that the man had described his self-harming as a coping mechanism but during the review had expressed no thoughts or intentions of harming himself.
48. The next day, 18 December, a prison GP discussed the man's medication with him. The man said that he was still getting pain in his foot, which was adding to his agitation and depression. The GP recorded that he wanted his current prescription of fluoxetine to be increased from 40mg to 60mg. The man told the GP that he was getting frustrated with all his problems and was having suicidal thoughts. The GP did not speak to anyone about what the man had said or record this in the ACCT document. The GP said that after further discussion he was content to have the prescribed levels left unchanged for the time being and did not want to be referred to drug services to help with possible addiction problems. The GP said that she had explained to him that he would need to have blood tests to establish whether a gluten-free diet was necessary. She said he was happy to do this.
49. On 18 December, the mental health team held their weekly multidisciplinary team meeting, which includes officers, probation, drug agency and healthcare staff. They discussed the man because of his self-harm on 16 December but not because of a TAG referral on 16 December instigated by the letter he had written in the event of his death. The meeting referred the man to a psychiatrist.
50. At 6.30pm that evening, a supervising officer chaired a further ACCT review. A wing officer was the only other member of staff present. The mental health nurse, who had agreed to attend the next review, does not appear to have been informed. The supervising officer said that she had been late on duty that day, as she had been attending another appointment. She did not realise that the man had an ACCT review scheduled until the end of the day, so had not been able to inform anyone else. At the review, the supervising officer recorded that the man was less agitated and said that he had not felt the need to cut himself. He said he had started taking his anti-depressant medication again which was helping. He assured staff that he would not self-harm. His risk of further self-harm was still assessed as raised but the frequency of observations was reduced to two an hour at night. The supervising officer told the investigator that she had made sure that the man was on what she considered a high level of observations overnight and she planned to do a full case review the next day with healthcare staff present.
51. On Thursday 19 December, a psychiatrist, reviewed the man after the referral from the multidisciplinary meeting. The psychiatrist recorded that the man had been self-harming for around 30 years and this had included suicide attempts by overdose. The man said that his recent self-harm had been a distraction from the pain he was having with his foot. He said that he was psychologically exhausted and, although he felt agitated, he knew that he was responsible for

his actions he told the psychiatrist that healthcare staff had not assessed or treated him adequately since he had been in prison. He said that he thought about suicide all the time, but had no immediate plans to carry it out. He told the psychiatrist that he always carried a razor blade with him and the psychiatrist told him that he would have to report this to prison staff. The man then said that he had made this up and had been testing the psychiatrist, who had now proved that he could not be trusted. The man then left the room.

52. The psychiatrist told the investigator that he considered that the man was at risk of self-harm but he had not thought it would be immediate. He used the term 'chronic suicidality' in his record. He explained that the man had suffered from suicidal feelings periodically for most of his life, it was not unusual him to say that he felt suicidal and this is what he had meant by 'chronic suicidality.' The psychiatrist did not record his contact with the man in the ACCT document but told the supervising officer about what he had said.
53. Later that afternoon, the same supervising officer held another ACCT review but no other members of staff were present. The supervising officer recorded that the man had said that he had been joking when he told the psychiatrist he had a blade. He said that he had no current intention to self-harm, but this could change. The supervising officer noted that she had telephoned the psychiatrist who had advised her to keep the observations at two an hour and review in a few days. She planned the next review for 21 December. The supervising officer said that she had intended to arrange for a member of healthcare staff to attend the review but it had not been possible to hold the review until 4.00pm, by which time no one from healthcare or another officer was available. She had been able to speak to the psychiatrist as he was holding a late clinic.
54. The supervising officer chaired the next ACCT review on Saturday 21 December, which a nurse from the mental health team attended. The supervising officer recorded that the man felt as settled as he could at the present time and was spending his time cleaning his cell and making it his own space. He said that he had continuing thoughts about harming himself, which he described as normal, but said he had no intention of acting on these. The man said that he wanted to get a prison job and was given some work to do in his cell to help keep him occupied. No change was made to his level of observations, which were maintained at two an hour, and his level of risk of further self-harm was still assessed as raised. The next review was scheduled for 26 December.
55. Each ACCT case review is supposed to review the caremap and update it. The case manager should indicate on the document that this has been done. At each of the man's reviews, the manager chairing the review ticked a box to on the record to indicate that the caremap had been reviewed and updated, but there is no evidence to support this, either on the caremap itself, or in the records of the reviews. A supervising officer told the investigator that she always looked at the caremap to see whether there were points that required updating. She acknowledged that there were some issues, such as him wanting a prison job, which she had discussed with the man and should have added to the caremap, but had not done so.

56. The wing officer, who attended most of the ACCT reviews, told the investigator that the man was usually 'bubbly' and talkative and often spoke about his family and things he had done in the past. The officer said that the man's main concerns had been about his medication and did not like having to collect one of his medications, which was a controlled drug, from the healthcare centre two or three times a day. He described the man as seeming happy on the wing. He had been allowed to paint his own cell, which he had been pleased with.
57. Another supervising officer held an ACCT review on Thursday 26 December, Boxing Day. No other member of staff was present. The supervising officer told the investigator that he had known the man well, including on previous occasions that he had been at Hewell. He recorded that the man's depression level was quite stable and that his main issue was his pain relief medication. He noted that mental health stabilisation was of paramount importance and that the man had said that he had suicidal thoughts, but would not act on them. In the record of the review, contrary to this, the supervising officer also wrote that he had no thoughts of self-harm and that the man said that he just wanted to help people and look after his family. The supervising officer assessed the man's level of risk as low and asked that he should be observed every two hours during the day and every hour at night and at other times when he was locked in his cell. The supervising officer recorded that the review took place at 10.55am and said that it had lasted around 25-30 minutes, ending between 11.20am and 11.30am. However, at 11.00am, a wing officer made an entry in the ACCT ongoing record, which said that the man was sitting on his bed watching television at that time. Neither member of staff was able to explain this discrepancy.
58. The supervising officer told the investigator that he had not invited anyone else to attend the ACCT review. He acknowledged that he had no mental health training and that his comments about his mental health were based solely on his own perception. He could not explain the contradiction between the different comments about whether the man had said he had any thoughts of self-harm.

#### New Year's Eve

59. The man continued to be monitored under ACCT procedures. Entries were made in his ACCT documents at appropriate times and no significant issues were raised. On 31 December, in response to the TAG referral on 16 December, a mental health nurse carried out a mental health assessment. The nurse noted that she was unsure of the purpose as, since the referral, two mental health nurses has seen the man after he had self-harmed and the psychiatrist had reviewed him on 19 December. The psychiatrist had asked that the man should be monitored at the weekly multidisciplinary meeting.
60. The nurse recorded that the man was initially agitated and said that he was aware of the risks of continued self-harm, including the possibility of disability and that he might die. The nurse said that the man did not appear to be anxious or depressed when she saw him but believed he would need to be assessed and monitored further as she considered that his mental state was volatile and there was a risk it would deteriorate.

61. Although the letter the man had written on 16 December in which he had outlined plans for after his death, had been the reason for the TAG referral, The nurse did not mention it during the assessment. She told the investigator that she was unaware of the letter and had not seen the TAG form, which had been completed.
62. The man was unlocked for association on the afternoon of 31 December and chatted with other prisoners. A wing officer said that, at around 5.30pm, the man asked him if he was going out for New Year's Eve, put his thumbs up and said, "Have a drink for me gov." The officer noted nothing out of the ordinary in his behaviour that afternoon.
63. At 8.55pm, an operational support grade (OSG), began his night duty on the unit. The day staff handed over to him and said that the man was the only prisoner being monitored under ACCT procedures. An officer had checked him at 8.26pm and recorded in the ACCT document that the man was lying on his bed and appeared to be asleep.
64. The OSG began a roll check to establish that all prisoners were present in their cells. He arrived at the man's cell at around 9.00pm and the cell was in complete darkness. The OSG said that when he looked through the door observation panel, he could see the man in silhouette. He appeared to be standing looking out of the window. The OSG turned the cell light on and asked him if he was all right. He then noticed that the man was facing towards him, his eyes were open and his head was tipped to the side. What looked like bed sheet material was protruding from the collar of the man's tee shirt. He could not see anything around his neck because his head was tipped over obscuring the right side of his neck. The OSG said that the man's feet were flat on the floor and his knees were only slightly bent. He could get no response from him.
65. The OSG tried to radio a code blue medical emergency (which indicates a prisoner is unconscious or not breathing) but his radio was not working. He therefore ran to the wing office, telephoned the control room and asked for immediate assistance, as he believed that the man was hanging from a ligature. The control room log indicates that the OSG telephoned at 9.00pm, and a code blue emergency was then immediately broadcast over the radio network. The log indicates that an ambulance was requested at 9.03pm.
66. A custodial manager, had arrived for duty at around 8.30pm and was in the gate lodge where the outgoing manager, was briefing him. It had been a busy day and two prisoners had been taken to hospital, which meant there was a reduced level of staff in the prison. The duty governor, was covering the segregation unit and there were two officers and seven operational support grades for the rest of the prison. A nurse and a healthcare assistant were based in the healthcare unit.
67. When the custodial manager and outgoing manager heard the code blue, the outgoing manager remained in the gate lodge while the custodial manager went to the houseblock, which he estimated took four to five minutes. When he got there, the OSG said there was a prisoner hanging and he directed him to the man's cell. The custodial manager checked it was a single cell and told the OSG to open the cell and they went in.

68. The custodial manager told the investigator that the man was suspended by what appeared to be some torn bedding attached to his locker. His feet were on the ground and he was at the right-hand side of the window. The custodial manager said that the man was completely unresponsive and the ligature was taking his full body weight. He believed from his appearance that he had been hanging for some time.
69. The custodial manager lifted the man's body while the OSG cut through the bedding and they lowered the man to the floor. The man was not breathing and the custodial manager could not find any signs of life. He asked the OSG to bring a resuscitation mask from the wing office and began cardiopulmonary resuscitation by chest compressions. When the OSG came back with the resuscitation mask, they both tried to ventilate the man but they could see no movement in his chest so continued with chest compressions.
70. The custodial manager radioed the control room to check that healthcare staff were on their way. He established that an ambulance had been called and ensured that the control staff understood that the man's condition was very serious.
71. A duty nurse and a healthcare assistant, were in the healthcare unit when they heard the code blue at 9.00pm. At the time, healthcare staff were locked in the unit at night and an officer had to collect them if they needed to attend any of the houseblocks. (This practice has since changed and nurses working at night now have a key, which allows them to leave the healthcare unit in an emergency.) The nurse and healthcare assistant collected the emergency equipment and waited for an officer to take them to the emergency incident. The nurse said that she did not know the exact time an officer arrived, but said it was 9.10pm when they got to the houseblock.
72. The nurse said that when they arrived at the man's cell, The custodial manager was doing chest compressions and the OSG was supporting the man's head. The nurse attached the defibrillator pads to the man's chest as the custodial manager continued chest compressions and the healthcare assistant took over supporting the man's head so that the nurse could put an airway tube into his throat. The healthcare assistant was ready with oxygen and a bag valve mask to administer oxygen to the man and the nurse then took over chest compressions and continued until the paramedics arrived, which the nurse thought was about 30 minutes later.
73. The control room log indicates that the ambulance arrived at Hewell at 9.10pm, seven minutes after being called, but that paramedics did not reach the man until 9.30pm. The twenty-minute delay was because the vehicle gates leading to the houseblock were 'double locked'. Double locks are used at night for additional security. The investigator was told that during holiday periods or at weekends when the workshop area (which is accessed through the same gates) was not being used, it had become practice to leave the double locks on the gates.
74. The staff, who were escorting the ambulance to the houseblock, were unaware that the gates were double locked until they reached them and were unable to get through. They then had to go back to the gate lodge to get the 'doubles'

keys and unlock each of the gates. Normally, only the night orderly officer has access to these keys, but fortunately, the outgoing manager was still in the gate lodge and had them. This issue significantly delayed paramedics arriving at the cell, although officers and nursing staff continued cardiopulmonary resuscitation in the meantime.

75. When paramedics arrived, they took over the resuscitation attempt and administered emergency medication. However, at 9.56pm the paramedics pronounced the man dead.

#### Support for prisoners and staff

76. The prison ensured that all prisoners who were subject to monitoring under suicide and self-harm prevention measures were reviewed and offered support in case they had been affected by the death. All prisoners were advised that the Chaplaincy team were available should they need to speak with them. A memorial service for the man was held in the prison chapel.
77. The staff who had been directly involved on 31 December attended a debrief immediately after the death and were offered support from the staff care team.

#### Family liaison

78. A prison's family liaison officer was appointed. The family liaison officer and a member of the chaplaincy team, , visited the man's nominated next of kin later that evening, however, as it was New Years Eve no one was at the family address and the prison were unable to trace the family. As a result, a telephone call and visit was made to the family the following morning. In line with national guidance, the prison offered assistance towards funeral costs.

## ISSUES

### The man's clinical care at Hewell

79. The clinical reviewer, noted that the man had a long history of serious self-harm as a means of coping with his physical pain and suffered from a personality disorder. His reasons for self-harming were fully recorded in his medical records and the clinical reviewer considered that on the whole, healthcare staff took appropriate action in response and recorded their interventions accurately, concisely and thoroughly. The clinical reviewer was satisfied that, overall, the man received clinical care equivalent to that in the community.
80. The clinical reviewer found that the healthcare staff involved with the man's care tried to ensure that his needs were met with in relation to his pain relief and psychiatric care. A nurse referred him to the mental health team on 16 December and the multidisciplinary team discussed his case on 18 December after an act of self-harm. The next day, 19 December, a psychiatrist reviewed him. The clinical reviewer commented that information discussed at multidisciplinary team meetings was not recorded on the SystmOne medical record, which would be good practice to ensure that all healthcare staff are aware of any interventions planned for a prisoner or of any specific concerns about them.
81. A nurse made a Threshold Assessment Grid (TAG) referral on 16 December and another mental health nurse was asked to assess the man on 31 December as a result. The clinical reviewer was concerned that the mental health nurse who conducted the assessment seemed to have been confused about its purpose, had not seen the original TAG referral. It is understandable that the nurse was unsure about the purpose of the assessment at that point, as the man had had other mental health interventions since the original referral, including an appointment with a psychiatrist. However, key information about the reason for the referral should have been communicated more effectively.
82. The man had a long history of mental health problems and had been seen by a psychiatrist at HMP Birmingham on 4 December who had asked the mental health team to review him a week later. When he arrived at Hewell on 5 December, we consider he should have been referred to the mental health team to ensure continuity of care. A nurse did not refer him to the mental health team until 16 December, although he had first self-harmed at Hewell on 12 December and he had told wing staff on 7 December that he was concerned that no one from the mental health team had seen him. While we are satisfied that the man subsequently received appropriate mental health intervention we consider that a referral from the point he arrived would have helped ensure this was more effectively coordinated. We make the following recommendation:
- The Head of Healthcare should ensure that prisoners arriving with identified mental health problems are referred to the mental health team for assessment to ensure appropriate continuity of care and that staff conducting assessments have all relevant information.**
83. The man was very concerned about his medication. He had asked for his diazepam dose to be increased when the prison GP reviewed his medication

on 11 and 18 of December and this was agreed on the first occasion. When she reviewed the man on 18 December, The GP was not willing to increase the dose further and tried to encourage him to see a doctor in the Integrated Drug Treatment Services (IDTS) Team as she felt he was addicted to diazepam. The man refused this offer. The clinical reviewer was satisfied that the man received appropriate medication, which was managed satisfactorily, and the level of his medication was appropriately reviewed.

84. The man said that he was lactose and gluten intolerant and needed a special diet. He was originally prescribed this but the GP recorded that there were no medical reasons for this recorded. Subsequently, the man was asked to take tests to check whether a gluten-free diet was required. His diet was evidently a matter, which concerned him, and he raised it at ACCT reviews and also asked the doctor to check this with his community GP. There is no record that anyone made enquiries with his GP about this or that the tests requested by the GP took place. We make the following recommendation:

**The Head of Healthcare should ensure that that when newly arrived prisoners report a need for a special diet, confirmatory checks are made with their community GP.**

### **Management of the ACCT process**

85. In the light of the man's history we are surprised that prison staff did not identify him as at risk of suicide and self-harm when he first arrived at both Birmingham and Hewell. However, staff at Hewell appropriately began ACCT procedures on 12 December, after he cut his arm and continued to manage him under ACCT procedures until his death. The man said that he had harmed himself on 12 December, as he was anxious and unhappy about his medication. On 16 December, he passed a letter to staff, which he had written to his father, outlining his wishes after his death. As a result his level of observations was increased. Later on 16 December, he self-harmed again by cutting his arm and said this was to distract himself from pain. The next day the frequency of observations was reduced to three an hour from five, after the man said that he had no thoughts or plans of suicide or self-harm and was content for the doctor to review his medication. At his last ACCT review on 26 December, a supervising officer reduced the man's levels of observation to once every two hours during the day and hourly at night. Despite some concerns about the composition of some case reviews, the level of the man's assessed risk at each review reflected what was discussed at reviews and the level of observations set was appropriate. However, we do not consider that the supervising officer should have reduced the level of observations on his own, and without any mental health input.
86. Information sharing could have been better and we note that on two occasions when he mentioned having suicidal thoughts to the doctor, the doctor did not share this information with anyone else. The first time, the doctor did not believe he was at such risk that an ACCT needed to be opened but she did not discuss this with anyone. The second time, the man was subject to an ACCT, yet she did not record this on the ACCT document or pass on the information.
87. There was little consistency of case management and four different managers chaired six case reviews. Most of the managers had no previous knowledge of

the man before they chaired the reviews. Prison Service Instruction (PSI) 64/2011, which gives guidance on safer custody procedures, requires that a case manager is appointed at the first case review and that where possible, the case manager should chair subsequent ACCT case reviews. The practice of relying on whoever is on duty at the time a review is due does not provide appropriate continuity of case management.

88. A safer custody officer drew up a caremap for the man on 17 December, but there is no evidence that this was reviewed or updated at any further case reviews, despite the case managers indicating that they had done so. The caremap did not contain all the necessary identified actions to help reduce his risk, such as a mental health referral.
89. PSI 64/2011 requires cases reviews to be multidisciplinary where possible, and include staff from departments involved in the prisoner's care. This requires some planning by the case manager so that others involved are aware when reviews are scheduled and can arrange to attend. However, it is apparent that a number of the case reviews were arranged at the last minute, which precluded this happening. Despite the man being under the care of the mental health team and his identified problems with medication, a different healthcare representative attended only two of the reviews. The others involved just wing staff. At two of the six reviews, on 19 and 26 December, the only member of staff present was the manager chairing the review, which is unacceptable
90. A supervising officer said that on 26 December he held a review alone with the man at 10.55am and that this had lasted for 20 to 25 minutes. However, an entry in the ongoing record made by a wing officer indicated that the man was in his cell at 11.00am watching television. Both accounts cannot be accurate but each member of staff has maintained that what they recorded was correct. It is a serious matter when ACCT records are not accurate and the Governor of Hewell has commissioned an internal investigation about this discrepancy.
91. There were a number of deficiencies in the operation of ACCT procedures at Hewell. While we cannot say that more effective ACCT procedures would have prevented the man's death, the prison did not manage the process in line with national guidelines to help ensure that he received the most effective support. We make the following recommendation:

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

- **Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner's care;**
- **Ensuring all staff are aware of their obligations to record relevant information in the ACCT document;**
- **Reviewing and updating caremaps at each review;**
- **Completing ACCT documents fully and accurately, including following the prescribed level of observations and recording them;**
- **Ensuring continuity of case manager, whenever possible.**

## Emergency response

92. National guidance about the use of medical emergency response codes is set out in Prison Service Instruction (PSI) 03/2013, issued in February 2013. The PSI contains a mandatory instructions that governors should have a protocol in place to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand the instruction and their responsibilities during medical emergencies. We are satisfied that, although the OSG had an initial unforeseen problem with his radio, a code blue was called quickly and appropriately. Although not immediate, the control room called an ambulance quickly after becoming aware of the emergency. Healthcare staff took appropriate emergency equipment to the man's cell.
93. However, there were some concerning delays in the emergency response. When the OSG found the man hanging, he waited until the custodial manager arrived before he went in. This was about five minutes after he had first found the man hanging. Usually cells should not be opened at night, but staff carry a key in a sealed pouch for use in an emergency. National instructions in PSI 24/2011 say that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff may enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger and should first make every effort to get a verbal response from the prisoner. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment of the situation. The OSG told the investigator that he had weighed up whether to enter the cell on his own but thought it was better to wait for a colleague to arrive as he was unsure of the situation and was not clear what he would be able to do on his own.
68. As the OSG had called an emergency code blue he had already assessed the situation as life threatening and he had noted that the man was hanging from a ligature. He knew the man was regarded as at risk of suicide and self-harm and was being monitored for that reason. While we understand that it is difficult for staff in such situations to make immediate decisions, when someone is found hanging it is essential to act quickly. In such circumstances we would normally expect staff to go into a cell as fast as possible, even if they are on their own.
94. A further delay was caused by healthcare staff having to wait for an officer to unlock them and take them to the houseblock. This meant they did not arrive at the cell until ten minutes after the code blue was called. As the custodial manager and OSG had already begun cardiopulmonary resuscitation the delay on this occasion is unlikely to have affected the outcome but in other emergencies this could be crucial. We consider that such a delay is unacceptable. Since this death nurses now have a key, which allows them to leave the healthcare unit to attend an emergency without waiting for an escort.

95. The lengthiest delay involved the ambulance crew reaching the cell once they arrived at the prison, which took twenty minutes. Hewell's local security strategy (LSS) sets out actions required to ensure that emergency vehicles have swift access including raising barriers and preparing manual overrides in advance during night state, which where necessary would include taking off double locks. Double locks, which require a separate key, had been left on the vehicle access gates in the workshop area which is the route used by emergency vehicles to get to the residential houseblocks. This led to unnecessary delays. The Governor accepted that double locks should not have been in place and that there had never been any official instruction to staff to justify this practice. Officers were available to escort the ambulance when it arrived so shortage of staff was not a contributory factor to the delay.
96. We do not know how long the man had been hanging when he was found and whether any of the delays directly impacted on his death. Nevertheless, a swift response in a life-threatening situation is vital and a number of the delays on this occasion were avoidable and unacceptable. We make the following recommendation:

**The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life and that emergency procedures allow healthcare staff and paramedic's swift access to prisoners who need urgent care.**

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners arriving with identified mental health problems are referred to the mental health team for assessment to ensure appropriate continuity of care and that staff conducting assessments have all relevant information.
2. The Head of Healthcare should ensure that that when newly arrived prisoners report a need for a special diet, confirmatory checks are made with their community GP.
3. The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner's care;
  - Ensuring all staff are aware of their obligations to record relevant information in the ACCT document;
  - Reviewing and updating caremaps at each review;
  - Completing ACCT documents fully and accurately, including following the prescribed level of observations and recording them;
  - Ensuring continuity of case manager, whenever possible.
4. The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life and that emergency procedures allow healthcare staff and paramedic's swift access to prisoners who need urgent care.



No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners arriving with identified mental health problems are referred to the mental health team for assessment to ensure appropriate continuity of care and that staff conducting assessments have all relevant information.	Accepted	<p>Written guidance will be provided to all staff reminding them that they need to make a referral to the Mental Health Team following the initial Reception Screen where there are identified mental health problems.</p> <p>Guidance to be issued ensuring that when staff are aware of any past mental health issues that they request the full details at the earliest possible time, i.e. If out of hours at the next working day.</p> <p>Ensure Mental Health staff have access to all up to date medical records on all prisoners</p>	<p>September 30th 2014 Head of Healthcare</p> <p>October 30<sup>th</sup> 2014 Head of Healthcare</p> <p>September 30<sup>th</sup> 2014 Head of Healthcare</p>	
2	The Head of Healthcare should ensure that that when newly arrived prisoners report a need for a special diet, confirmatory checks are made with	Accepted	Confirmatory checks are to be introduced in consultation with the prisoner. The reception staff will forward information to the administration team who will contact the community GP.	September 30th 2014 Head of Healthcare	

	their community GP		A system will be introduced ensuring prisoners are asked to give consent in Reception for us to gain their community GP records.	September 30th 2014 Head of Healthcare	
3	<p>The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> <li>• Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner's care;</li> <li>• Ensuring all staff are aware of their obligations to record relevant information in the ACCT document;</li> <li>• Reviewing and updating caremaps at each review;</li> <li>• Completing ACCT documents fully and accurately, including following the prescribed level of observations and recording them;</li> <li>• Ensuring continuity of case manager, whenever possible</li> </ul>	Accepted	<p>Timetable Reviews to be completed at dedicated times of the day to improve accountability and attendance. A degree of flexibility will be retained allowing to respond to the changing circumstances. This will be kept under review</p> <p>Training to be developed and delivered highlighting any weaknesses in local ACCT process and targeting case managers</p> <p>Guidance to be issued to all case managers detailing need to review and update care maps at each review.</p> <p>Notice to staff to be issued derailing requirement to follow observations and ensure that these are recorded correctly</p> <p>Daily meeting to be scheduled between safer custody and Healthcare ensuring all relevant information is shared between both functions.</p>	<p>30<sup>th</sup> September 2014 Head of Safety</p> <p>30<sup>th</sup> September 2014 Head of Safety</p> <p>30<sup>th</sup> November 2014 Head of Safety</p> <p>Completed Head of Safety</p>	
4	The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should	Accepted	Notice to staff to be issued on personal risk assessment for cell entry during night state.	30 <sup>th</sup> September Head of Safety	

	<p>enter a cell at night when there is potentially a risk to life and that emergency procedures allow healthcare staff and paramedics swift access to prisoners who need urgent care</p>		<p>Review Emergency procedures during night state to ensure swift access to prisoners</p> <p>A Review has been conducted on how keys are allocated during night state to the healthcare team so they have swift access to prisoners.</p>	<p>Completed Head of Security</p> <p>Reviewed and completed Head of Security</p>	
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