PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Manchester in February 2012

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

Ashley House, 2 Monck Street, London SW1P 2BQ Tel: 020 7035 2876 Fax: 020 7035 2012
E-mail: mail@ppo.gsi.gov.uk www.ppo.gov.uk

This is a report into the circumstances surrounding the death of a man, a prisoner at HMP Manchester, in February 2012. He was 52 years old. He had been in custody since 12 December 2011 and transferred to HMP Manchester on 16 December. I offer my condolences to the man's family.

One of my colleagues conducted the investigation. NHS Greater Manchester commissioned a clinical review into the standard of healthcare the man received. An Associate Clinical Director completed the review on their behalf. Manchester prison cooperated fully with the investigation.

The man transferred to Manchester on 16 December from HMP Liverpool as he was regarded as a Category A prisoner needing high security conditions. He was subject to suicide prevention procedures until 28 December when he was considered to be no longer at risk of self-harm. On a day in February 2012, while unlocking prisoners to attend afternoon education courses, prison officers found the man behind the door, hanging by a piece of fabric tied around his neck and attached to the bed. Prison officers, healthcare staff and paramedics attempted cardiopulmonary resuscitation but the man did not respond. At 2.45pm, he was pronounced dead.

Assessing the risk a prisoner poses to himself is not an exact science and involves balancing his demeanour and behaviour against known risk factors. The man was not subject to self-harm monitoring at the time of his death. While he seemed settled and caused staff little concern, it appears that too much reliance was placed on his personal presentation rather than an objective assessment of all the risk factors in his case – including the fact that he was charged with a highly publicised double murder, had received the highest security categorisation and had only been in prison a short time when his suicide prevention monitoring ended. Nevertheless, it would have been difficult for prison staff to foresee the man's actions and it is not possible to conclude that additional monitoring could have prevented his death.

The man's family received a copy of the draft version of the report as part of the consultation period. The man's family told my family liaison officer that they had no further comments or feedback they wished to provide on the report.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2012**

CONTENTS

Summary

The investigation process

HMP Manchester

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was remanded into the custody of HMP Liverpool on 12 December 2011, charged with murder. Before his remand, he had been detained in police custody, and commented to officers that he would harm himself if he was charged with the offences. When he arrived at Liverpool, this information was passed to prison staff who placed him under the suicide and self-harm prevention procedures known as Assessment, Care in Custody and Teamwork (ACCT). During the assessment, the main issues identified by the man were the need to maintain contact with his family, concern about what would happen to him and potential boredom.

2. The man transferred to HMP Manchester on 16 December. On his arrival, a member of the prison's mental health in-reach team (MHIRT) interviewed him and he denied any thoughts or intentions of self-harm. Although the assessment was recorded in the ACCT document, contrary to policy, no case review took place on his arrival. Staff continued to monitor him under the suicide and self-harm provisions and reviews subsequently took place. Despite a number of risk factors in his case, the man's risk was assessed as low and, when the identified issues of concern in his ACCT document were addressed, the self-harm monitoring ended on 28 December.

3. The man was located on the vulnerable prisoner wing and was thought to have settled in well, despite his initial apprehension. He was said to have mixed well with other prisoners and staff, who described him as always smiling and jolly. He attended education classes to keep him occupied and associated with other prisoners each day. Unfortunately, none of this is documented in his case notes either by a personal officer or other residential staff.

4. On the afternoon of a day in February 2012, staff unlocked the man to attend an education class and discovered him hanging from the end of his bed by clothing tied around his neck. Staff called for medical assistance and immediately started cardiopulmonary resuscitation (CPR).

5. Nursing staff, prison doctors, and paramedics responded and efforts continued to resuscitate the man. However, he did not respond to treatment and at 2.45pm, he was pronounced dead.

6. The investigation found that some managers responsible for carrying out ACCT reviews were not trained for the role and a case review on transfer did not take place as required in Prison Service guidance. We have made recommendations on these issues, but are satisfied they would not have affected the outcome for this man. What is of more concern is that the assessment of risk did not appear to take account of all his known risk factors and relied heavily on his personal presentation. As a result, the ACCT was closed at an early stage.

7. A clinical review of the man's medical care concluded that his treatment in prison was satisfactory.

8. We conclude that it would have been difficult for the staff involved in the man's care to foresee his actions on the day of his death and that the attempts to resuscitate him were satisfactory.

THE INVESTIGATION PROCESS

9. One of my colleagues carried out the investigation. On notification of the death, he contacted HMP Manchester and arranged for copies of the man's prison and medical records to be prepared. Notices were issued to staff and prisoners informing them of the investigation. The investigator visited Manchester on 15 February to open the investigation, speak to staff and prisoners, and collect the relevant documents.

10. NHS Greater Manchester were asked to commission a review of the medical care given to the man in custody. The review was completed by a clinical reviewer.

11. One of our family liaison officers spoke to the man's next of kin on 6 March. The family liaison officer explained the investigation process and the role of the Ombudsman's office, as well as offering a copy of the investigation report. His family raised no issues or concerns to be considered during the investigation.

12. The investigator contacted HM Coroner to inform him of the investigation and to obtain a copy of the post mortem and toxicology reports.

13. On 2, 3 and 4 April, the investigator returned to Manchester to conduct interviews with prison staff, assisted by an Assistant Ombudsman. Following the interviews, both verbal and written feedback was provided to the Governor.

14. Following the consultation period HMP Manchester accepted in full, the recommendations made in this report.

HMP MANCHESTER

15. HMP Manchester is a high security prison near the centre of the city. It also operates as a local prison, serving the courts of the Greater Manchester area. It holds up to 1,269 adult male remand, convicted and sentenced prisoners.

16. Healthcare at HMP Manchester is commissioned by NHS Manchester and provided by Manchester Mental Health and Social Care Trust. The prison provides 24-hour nursing care and the healthcare centre includes an in-patient unit. Primary care services include access to a range of in-house and visiting specialist clinics. There is a full-time doctor, supported by a part-time doctor and locums, the healthcare team is nurse led. Qualified general and mental health nurses and healthcare assistants make up the permanent healthcare team. Specialists in mental health, dental care, opticians and areas of secondary care visit the prison on a regular basis.

Her Majesty's Chief Inspector of Prisons

17. HM Chief Inspector of Prisons (HMCIP) last carried out an inspection of Manchester in September 2011. In the summary of their latest inspection, HMCIP addressed the self-inflicted deaths at the prison, and said:

> '…Our most serious concern about the prison was the high level of self-inflicted deaths. This had been the case for many years and was higher than most other prisons. There had been seven self-inflicted deaths since the beginning of 2009, five of them since our last inspection in July 2009. There was a degree of fatalism in the prison's response to this – that was the way things were in Manchester I was told. Arrangements for caring for prisoners at risk of self-harm or suicide were not poor but there was room for improvement. The prison was not active enough in ensuring lessons were learnt from previous cases (both at Manchester and elsewhere) and ensuring they were consistently applied. As a matter of urgency, the prison needed to apply the same vigour and determination to this issue as it had to others. Its own health department's approach to serious incidents, near misses and deaths in custody generally was good practice and an obvious starting point for tackling the specific issue of self-inflicted deaths…'

18. The Inspectorate observed friendly and relaxed interactions between staff and prisoners but noted that this had not developed into fully effective personal officer work. Personal officer case notes were infrequent and lacked depth. In the inspectorate's survey of prisoners more than half said they did not have a personal officer. Inspectors found that personal officer case notes were "often cursory, lacked detail and said very little about individual circumstances."

Independent Monitoring Board (IMB)

19. Each prison in England and Wales has an Independent Monitoring Board (IMB). Members of the Board are volunteers from the local community who monitor day-to-day life in the prison to help ensure proper standards of care

and decency. Manchester IMB published its most recent annual report in May 2012. It covers the period from March 2011 to February 2012. The Board said:

> '…The prison makes a big commitment to safer custody and there are several strategies in place to make the prison a safer place. Examples are Violence Reduction, Anti Bullying, Suicide Prevention and Self Harm Management and Anti Social Behaviour…
>
> 'Following the unannounced inspection in August/September 2011, Her Majesty's Chief Inspector of Prisons (HMCIP) made comment that the prison needed to focus on the high level of self inflicted deaths. He said that whilst arrangements for caring for prisoners at risk of self harm were not poor, there was room for improvement. Following this a task force was established, before the end of 2011, to tackle this issue. The cross-agency, cross-discipline task force consists of health professionals, external experts, national leads, Samaritans, prisoners, voluntary sector specialists, who are looking afresh at everything that is done around suicide prevention, training, inquest outcomes and Prison and Probation Ombudsman (PPO) reports, so that an improvement can be seen as soon as possible.
>
> 'There is a Safer Prisons Team…a full time Safer Custody Manager and a deputy in post. Meetings are held for all these strategies each month. Board members regularly attend these meetings as observers. Outside bodies such as Samaritans are also involved. Prisoner representatives such as wing Listeners also take part.'

Previous deaths at Manchester

20. Since 2009, there have been nine self-inflicted deaths at Manchester including this man's. The previous death occurred only a few weeks before. We repeat a recommendation from that investigation about training staff in the suicide prevention and self-harm management procedures.

Assessment, Care in Custody and Teamwork (ACCT)

21. Assessment, Care in Custody and Teamwork (ACCT) is the process used in all prisons to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT monitoring, the prisoner is subject to regular case reviews that will direct supervisions/conversations to be carried out at intervals determined by their perceived level of risk. The supervisions continue during the day and the night.

Cardiopulmonary Resuscitation (CPR)

22. This is an emergency procedure which is performed in an effort manually to preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person in cardiac arrest.

Automated External Defibrillator (AED)

23. These are portable units, used in life-threatening emergencies to analyse heart rhythm and advise whether a controlled electric shock is required. They are designed to be easy to use by non-medical persons, who require little training to operate them correctly. Paramedics on arrival at an emergency will usually replace the AED with their own more sophisticated equipment.

KEY EVENTS

24. The man was remanded at a Crown court into the custody of HMP Liverpool, on 12 December 2011. He was 51 years old and had been charged with murder. On his arrival at Liverpool, the police informed prison staff that the man had stated that he would attempt to take his own life if he had to stand trial.

25. During the reception procedures, an officer asked the man about his threat to take his life. He said that he felt low and worried. If unable to prove his innocence, he said he would attempt suicide. It was recorded that he had previously been in custody in 2001 and had harmed himself during this time. Staff began monitoring him under the suicide prevention procedures and opened an ACCT document. Nursing staff then completed an initial health screen.

26. Records show that the man had been receiving regular medication to treat high cholesterol and that he had a history of psoriasis (dry skin.) The man said that he had never used drugs and drank very little alcohol. No previous mental health problems were recorded and staff confirmed by checking computer records that he was not known to community mental health services.

27. Due to the nature of the alleged offences as well as the public interest in the case, the prison applied for the man to be considered for category A status on the day he arrived at Liverpool. Prisoners are categorised into one of four groups, A, B, C or D, when they arrive into custody. Category A is the highest security level and is for those whose escape would be highly dangerous to the public or national security.

28. On 13 December, an officer carried out an ACCT assessment with the man. During the assessment, the man said that at times he had thoughts of suicide as he felt he would get a long sentence and missed his son. He denied the charge and said that his solicitors had told him that he had a good case. The officer asked about previous attempts at self-harm and the man said that, while in custody in 2001, staff had saved him when he had attempted to hang himself. The man said that when he did this he was in a low mood, and could see no way out, but kept thinking about how his son would feel.

29. The man told the officer that he had never seen a psychiatrist, neither had he been treated for depression. When asked about how he was currently feeling, he said that, while he felt isolated, he wanted to be on his own. He told the officer that in police custody he had been on constant supervision, but had had no plans to harm himself. He said that his son was his only reason for living.

30. After the assessment, the officer, a senior officer and the man had a case review. The senior officer recorded on the ACCT document that the man was concerned about his family due to the high profile nature of his case. Again, he admitted to fleeting thoughts of self-harm, but said he had no plans to act on them. The senior officer also recorded that the man expressed some concerns about his health, and how his ongoing medical conditions would be managed.

He was told that any healthcare issues would be dealt with. The senior officer concluded that due to the man's continued low mood and the nature of his charges, he would continue to be monitored and his level of risk was considered at that time to be raised. The key issues to be addressed during the ACCT process were summarised as: maintaining contact with his family, a lack of information about his healthcare and boredom.

31. On 14 December, the man was assessed as category A. Only a small number of prisons in England are able to accommodate category A prisoners. The closest to Liverpool is Manchester and he transferred there on 16 December.

32. On his arrival at Manchester, a member from the prison's mental health in-reach team (MHIRT) assessed the man at the request of the reception nurse. There were no identified concerns about his mental health, and this was a precautionary assessment because of the nature of the charges against him. This was not a full mental health assessment, rather to identify whether further mental health support was needed at that time. No immediate mental health concerns about the man were recorded.

33. The member from the prison's mental health in-reach team recorded that the man was bright in mood and warm, friendly and engaging. When she asked about his thoughts of self-harm, he denied that he had threatened to kill himself, but spoke about his previous attempts in 2001. The man told her that he now wanted to 'get his head down … get a cleaner's job' and attend education classes to occupy his mind. He said that he was fully aware of all the support that was available to him should he need it. The mental health in-reach worker's contact with the man was recorded in the ACCT document, but no ACCT case review took place.

34. Due to the nature of the charges and, at his own request, the man was given a cell in E wing, the vulnerable prisoner (VP) wing. An officer completed an initial induction session with the man. The officer told the investigator that he was aware of the circumstances surrounding the man's arrest because of press coverage. The officer described him as polite, pleasant and 'happy-go-lucky', and did not appear to be upset. The only thing he asked the officer to do was contact his ex-wife and let her know that he was now at Manchester, which he did.

35. The officer explained that he was aware that the man was subject to suicide prevention monitoring and he had made a note of this on the induction document. He had asked the man about the reasons for his previous self-harm. He replied that at that time 'his head was up his backside' but he was all right now. The officer said that the man was keen to point out that he was innocent of the charges and that everything was going to be all right. They also discussed his previous periods of custody and the officer reminded him of the support available such as Listeners, access to Samaritans and staff if he felt the need to talk.

36. The officer said that a senior officer (SO) was present for part of the first night induction. They explained to the man the significance of being both a category

A and a vulnerable prisoner, and the regime for such prisoners. For security reasons, category A prisoners are not allowed to leave the wing to attend employment in the workshops and they are unlocked to associate with others of the same status once all other prisoners have left the wing. Education is provided as it does not involve leaving the wing.

37. On 21 December, five days after his arrival at Manchester, a senior officer chaired an ACCT case review, attended by the man and a member from the MHIRT. The man felt he had settled well on E wing, and was focused on clearing his name when he eventually went to trial. He told the review that he was getting on well with the staff and other prisoners, but it could get noisy on the wing at times. When asked about thoughts of self-harm, he said that he had had no such thoughts since arriving at Manchester.

38. The senior officer said that they also talked about the man's previous employment. He appeared to be a very confident man who was keen to talk about his forthcoming trial, and appeared very positive about this. The senior officer said that the man was quite dismissive during discussion about thoughts of self-harm, and seemed surprised that anyone would think someone like him would want to harm themselves. He asked the man about supportive factors, and he mentioned his family, but did not speak about this in any real depth.

39. The man said that he was bored and would appreciate something to occupy him. They talked about the gymnasium and education classes, which the senior officer agreed to look into for him. This was reflected in the Caremap. It was agreed that the man would continue to be monitored, despite his positive outlook, as he had only been at Manchester for one week. It was recorded that there should be at least five observations and conversations, both during the day and at night, and these should be supported by quality entries made in the ACCT document. The man's level of risk was recorded as low.

40. The senior officer told the investigator that he had not received the relevant training to perform the duties of a case manager during ACCT reviews, but as a manager on E wing he was required to conduct them.

41. On 28 December, a further ACCT review was held, attended by the man and a member from the MHIRT, and chaired by a senior officer. They noted that the man was now attending education classes in the afternoons, and that he found this a welcome distraction from the boredom of the wing. He said he had no thoughts of self-harm or suicide and was settled. After discussion, it was agreed that the ACCT monitoring should end. He was told that, if he started to feel low, he should not hesitate to speak to staff. As a category A prisoner, he was still subject to closer monitoring than other prisoners. A post-closure interview was scheduled within 7 days to check on him and ensure that he was still coping without the support of the ACCT process.

42. A senior officer carried out the post-closure review with the man on 4 January. He confirmed with the man that he was maintaining contact with friends outside prison and had been issued with a PIN (Personal Identification Number) to use the prisoners' telephone system. He told the senior officer that he was familiar

with the routine on the unit, and where to get information if he needed it. The senior officer discussed the Caremap targets set when the ACCT was opened and the man said that they had all been addressed. The Caremap aims to identify issues that might have led to a prisoner being at risk of suicide or self-harm and prescribe meaningful actions to address them and assist the prisoner to overcome their period of crisis.

43. The man told the senior officer that he felt settled. He was confident working on his case and kept busy by attending education classes. The senior officer told the investigator that before the post-closure review, he had contact with the man while working on the unit and that he was always smiling and would 'have a laugh' with both staff and other prisoners. He described him as one of the most 'jolly ones' on the unit.

44. The man continued with education in the afternoons, and raised no issues or concerns about his well-being after the closure of the ACCT. Similarly, staff recorded no concerns about him.

45. The man had regular contact with nurses to collect medication for high cholesterol. On 8 January, he complained of a swollen ankle. He was assessed by a nurse, who diagnosed a sprain and prescribed anti-inflammatory medication. During a follow-up appointment the next day, he told nurses he did not wish to continue taking his cholesterol medication, and it was stopped.

46. On 11 January, the man told a nurse that his ankle was getting better slowly. He was asked again about his decision to stop taking his cholesterol medication and advised of the possible consequences of not doing so. Despite this advice, he reiterated that he did not wish to take it any longer, but gave no reason for his decision.

47. During interviews, staff said the man interacted well with staff, but he chose not to mix much with other prisoners. The senior officer, who had met the man when he first arrived at Manchester, said he spoke to him most days. He was always 'upbeat' and would either be watching television in his cell or out on the wing, but never gave cause for concern. This view of him was also reiterated by other wing staff who saw him daily on the wing. However, none of this was recorded contemporaneously. There were no entries from the man's personal officer in his P-Nomis case notes in the weeks leading up to his death and no other entries which would give an indication of his state of mind or demeanour at the time.

48. On a day in February, a senior officer was on duty on E wing. The investigator asked whether he could recall seeing the man during the morning. He replied that he probably would have, as he would have been unlocked after other prisoners had left for work, but he could not recall a particular interaction. He said that he would have also seen him at lunchtime, as he was usually first in the queue to collect his meal, but again he had no memory of any significant contact. No-one seems to have noted anything about the man's demeanour on that day.

49. An officer conducted the daily physical examination of all the cells on E wing during the morning of the same day, to ensure that walls, door locks, and windows had not been tampered with. This would have been between 10.00am and 11.30am. He told the investigator that when he went to the man's cell he was lying as he normally did on top of his bed and appeared to be his usual self.

50. At around 2.10pm that afternoon, an officer was unlocking prisoners to attend their classes. When he arrived at cell 12, occupied by the man, he looked through the observation panel in the door. He expected to see the man lying on his bed waiting to be unlocked, as usual, but when he looked in he could not see him. The officer asked his colleagues whether the man had been collected for a visit. At this point, an officer, who was assisting with the unlocking, entered the man's cell and found him hanging behind the door.

51. The officer who originally unlocked the prisoner called to other staff on the unit, informing them that there was a 'priority 1' medical emergency. The 'priority 1' call is an emergency code used to notify medical staff of a life threatening emergency. He told the investigator that he could see that the man was at the end of the bed, with what appeared to be an item of clothing tied tightly around his neck and fixed to a table that he had placed on top of the bed. The officer who found the man passed his cut-down tool to his colleague and, while he took the man's weight, his colleague tried to cut the fabric from around his neck. (A cut-down tool is a piece of equipment, carried by prison staff, to be used when prisoners are found hanging). The officer said that the thickness of the fabric made it difficult to cut and, as he got halfway, he attempted to get it over the man's head, but could not do so. He continued to cut the fabric and then realised that the man had tied a second strip of fabric underneath made from torn bed sheet. Eventually, he was able to release the man. The two officers then laid him on the floor, and the officer who originally found the man began CPR.

52. A senior officer heard the call for assistance, entered the cell and checked the man for a pulse. Other wing staff attended and instructed the officers to lift the man outside the cell to provide more room to treat him. An officer had collected the defibrillator (AED) from the wing office and attached it to the man, once he was outside of the cell, as nursing staff arrived.

53. Two nurses arrived and took over CPR from the discipline staff at around 2.15pm. The nurses brought with them two emergency medical bags. Another nurse arrived a few minutes later with a further emergency bag containing oxygen. She assisted the two other nurses in attempting to resuscitate the man. A prison doctor then arrived. He attempted to get a cannular (small flexible tube) into the man's hand to administer adrenaline to assist resuscitation, but was unsuccessful.

54. Another prison doctor arrived at 2.40pm, along with ambulance staff who had been requested after the initial 'priority 1' call. The doctor confirmed that nursing staff had been attempting CPR since 2.17pm and that wing staff had started this immediately after the man was discovered. He said that he noted

that attempts by his colleague to insert a cannular had failed, as the man's veins had collapsed, but an airway had been inserted. He had been unresponsive throughout the emergency treatment and at 2.42pm, the AED indicated that there was no shockable rhythm.

55. The second doctor to arrive in the cell recorded that CPR had been continuous for approximately 25 minutes, without success, and advised that attempts should cease. The first doctor to arrive in the cell asked to make a further attempt to get cannular access to administer adrenaline so the team agreed that CPR should continue. This was again unsuccessful and at 2.45pm all present, including the paramedics, agreed to stop treatment. The second doctor to arrive in the cell pronounced the man dead.

Events following the man's death

56. The prison arranged for all staff involved in the resuscitation attempts to attend a debrief immediately after his death and they were offered support from the staff care team. Nurses said that they were supported by their colleagues and given the opportunity to discuss the events. The prison also arranged for a critical incident de-brief to take place.

57. Following all deaths of prisoners at Manchester, staff carry out ACCT case reviews of all other prisoners who are subject to self-harm monitoring. The man's death came a short time after the death of another prisoner on the same unit. As a result, the prison took additional measures, providing extra staff both day and night, to support the prisoners on E wing.

58. The police attended shortly afterwards. They spoke to staff involved, and removed all correspondence from the man's cell to be passed to the Coroner. This is usual in cases of self-inflicted death. The man had left a number of letters to his family explaining his actions. Copies of these were given to the investigator. They indicated his intention to take his own life as he did not believe he would receive a fair trial because of press coverage of his case.

59. The duty chaplain that day was appointed as the prison's family liaison officer and had been trained to carry out that role. He visited the man's family later in the afternoon on the day of his death to inform them of the death and the various procedures that would take place. The family were asked whether they had any concerns or if they wished to visit the prison. They raised no immediate concerns and declined the offer of visiting the prison. The chaplain remained in contact with the family and helped with arrangements for the funeral. An offer of financial assistance towards funeral expenses was made.

ISSUES

Medical care

60. A clinical reviewer conducted a review of the man's medical care. He commented that the medical notes were of a high standard, clear, chronological and accurate. He noted that the man was given an appropriate health screen. He added that he was seen promptly by the Mental Health In-Reach Team and he was of the view that the resulting assessment was thorough. We note that the clinical reviewer explored with clinical staff the policy on referring prisoners for psychiatric assessments. The responses are not noted in his report but we are surprised that, in view of the nature of the charges against the man and the absence of much information about his past, a more detailed psychiatric assessment was not undertaken.

61. The clinical reviewer also considered that the man's physical health concerns were appropriately managed. In terms of the emergency response he was satisfied that the resuscitation efforts were prompt and sustained for an appropriate length of time. He pointed out that one of the doctors involved had extensive experience of resuscitation techniques from working in hospital accident and emergency departments. We agree with the clinical reviewer's view that the man's clinical care, and the resuscitation attempt, was satisfactory.

Management of the suicide prevention and self-harm procedures

62. When the man was first remanded into custody, staff at HMP Liverpool appropriately initiated suicide and self-harm prevention monitoring and support procedures following information from the police that he had expressed intentions to attempt suicide. A trained assessor carried out an assessment within 24 hours of his arrival to identify the man's issues, concerns and protective factors. The Caremap in the ACCT document showed that the issues of most concern to the man were contact with his family, his healthcare in custody and boredom. Levels of observations and interactions were clearly written on the front of the ACCT document and there was evidence within that staff adhered to them. Staff dated and numbered the case reviews chronologically.

63. Following his transfer to Manchester, a member of the prison's MHIRT assessed the man and recorded their meeting in the ACCT document. However, no case review was held until five days after the man arrived at Manchester, on 21 December. This was chaired by a senior officer and attended by the member of the prison's MHIRT. It appears to have been the next arranged review date, originally set at Liverpool, rather than a dedicated post transfer review. Guidance on the procedures states that a case review should be held whenever a prisoner changes location or transfers to another prison. This should have taken place as soon as the man arrived at Manchester, and the review dates amended accordingly. We therefore make the following recommendation:

The Governor should ensure that staff conduct a case review, on arrival, for all prisoners transferred to Manchester subject to ACCT monitoring.

64. During the first review, the man's concerns were recorded and amendments made to the Caremap, which indicated that he felt bored and had requested to work. The panel reviewed his level of risk, and despite his perceived positive outlook, they agreed that he should remain subject to ACCT monitoring as he had only been at the prison for a short time. This was an appropriate conclusion.

65. A further review, chaired by a different senior officer and attended by the same member of the prison's MHIRT team was held on 28 December. They updated the Caremap to indicate how the goals had been addressed. Notably, the man had been attending education classes to relieve his boredom. His level of risk was again reviewed and discussed by those present. It was decided to end the monitoring and hold a post-closure review within seven days. While we are satisfied that a full review was conducted and that all relevant issues identified in the Caremap were followed up, we are concerned at the assessment of the man's risk throughout the ACCT process.

66. Prison Service Order (PSO) 2700, Suicide Prevention and Self-harm Management, was the guidance in place at the time of the man's death. The PSO advised prison staff to be aware of the increased risks to a prisoner who has been charged with murder and those who have had a recent change to their security category. The man met both these risk criteria and in fact he had been charged with two murders. He had also self-harmed during a previous prison sentence. We would add that the level of press interest in the man's case was also likely to have made him more vulnerable. However, these factors do not appear to have been reflected in the level of risk assigned to him at his review on 21 December when it was regarded as low. This judgement appeared to be based almost wholly on the man's personal presentation rather than any of the other risk factors. At the time, he had been in prison only for two weeks, had just been made a Category A prisoner and had transferred to Manchester just five days earlier. In view of the nature of his charges, the press coverage and recent security change, a higher assessment of the level of risk would appear to have been more appropriate.

67. The assessment of the risk level as low, in turn led to the closure of the ACCT monitoring at a review a week later, on 28 December. This appears premature. While we cannot say that if the man had continued to be supported through the ACCT procedures this would have prevented him from taking the action he did, it would at least have meant that there was some record of how he was feeling in the weeks leading up to his death. We note with concern that the lack of entries in his P-NOMIS records mean that there is no contemporaneous account of the man's demeanour. We are aware that the lack of personal officer and other entries in prisoners' case notes was a concern identified by the Inspectorate of Prisons at its last inspection of Manchester in 2011. We make the following recommendations:

The Governor should ensure staff take fully into account all indicators of risk when assessing the risk of self-harm in prisoners.

The Governor should ensure that wing staff make regular entries in P-Nomis case notes outlining their interaction with prisoners, the prisoners' individual circumstances and any identified concerns.

68. The post closure review was carried out within the required timeframe and a record of the issues raised and discussed recorded. The Caremap actions were clarified during the review and the man confirmed he was satisfied that they had been appropriately addressed.

69. A previous investigation at Manchester found that unit managers responsible for carrying out and chairing case reviews were not appropriately trained to fulfil this role. This also applied to the management of the man's ACCT monitoring. The investigator heard from senior officers that, regardless of their level of training, if they were on duty then they would be expected to carry out this role.

70. Prison Service Order (PSO) 2700, the Prison Service policy in force at the time of the man's death, requires that staff who act as case managers in the ACCT process must be of the rank of senior officer or above and have completed case manager training. In addition, officers temporarily promoted should also be given case manager training before covering such duties. The two senior officers/case managers in this case, although sufficiently senior to undertake the task, had not received adequate training. Although we are satisfied that they performed the role competently, it is important that staff are appropriately trained to deal with such critical processes. We make the following recommendation:

The Governor should ensure that managers, including those on temporary promotion, have the necessary training before fulfilling the role of ACCT case manager.

CONCLUSION

71. Prison staff started to monitor the man under the suicide prevention provisions immediately on his arrival into prison, following statements he made to police while in their custody. This continued when he transferred to Manchester. Although it was clear that he had a number of concerns, during ACCT case reviews and assessments with mental health staff, he denied any intention to harm himself and gave his family as a factor which would prevent him doing so.

72. The man indicated he was confident to approach staff on the VP unit. He did not mix much with other prisoners but talked openly to staff. In his interactions with staff, he gave no indication that he was struggling to cope. We accept that the man's outlook appears to have been positive, but we consider that staff placed too much reliance on his personal presentation rather than stepping back and considering the other risk factors. He had only recently been charged with two highly publicised murders, been made a category A prisoner, had self-harmed during a previous prison sentence and had been in prison only three weeks when his ACCT monitoring ended. After that there was no documented account of the man's time at Manchester. We have made recommendations about these matters and some procedural areas for improvement in the operation of the ACCT process.

73. In letters the man left for his family, he indicated that he believed that media interest in his case would prevent him from receiving a fair trial, and this concern may have been a possible reason for his actions. Despite the concern about the ACCT risk assessments we consider that it would have been very difficult for staff on E wing to have foreseen the man's actions on the day he died. When he was found, the resuscitation efforts by officers and medical staff were appropriate.

RECOMMENDATIONS

1. The Governor should ensure that staff conduct a case review, on arrival, for all prisoners transferred to Manchester subject to ACCT monitoring.

   HMP Manchester has said:

   All relevant managers will be detailed to attend the ACCT Case Manager Training if they have not attended during the last 12 months. A Notice to Staff will be published to remind all staff that if a prisoner transferred into the establishment on an ACCT document, a case review must be convened on their arrival.

2. The Governor should ensure staff take fully into account all indicators of risk when assessing the risk of self-harm in prisoners.

   HMP Manchester has said:

   All staff are currently undergoing refresher ACCT Training. During this training, discussions take place regarding static and dynamic risk factors for suicide and self-harm.

3. The Governor should ensure that wing staff make regular entries in P-Nomis case notes outlining their interaction with prisoners, the prisoners' individual circumstances and any identified concerns.

   HMP Manchester has said:

   A Notice to Staff will be published reminding staff of the need to record information regarding prisoners, both positive and negative on Prison-NOMIS

4. The Governor should ensure that managers, including those on temporary promotion, have the necessary training before fulfilling the role of ACCT case manager.

   HMP Manchester has said:

   As above, all relevant managers will be detailed to attend the case manager training if they have not attended in the last 12 months.