PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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

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 of the investigation into the death of a man who died at HMP Manchester in December 2012. He was 41 years old. He was found hanging from the window bars of his single cell with a ligature made from bed linen around his neck. I offer my condolences to his family and friends.

A clinical reviewer carried out a review of the clinical care the man received at Manchester. The prison cooperated with the investigation.

The man had been abused as a child and had a deep and open dislike for those he thought had committed sexual offences or domestic violence. He said that he would harm anyone he thought guilty of such offences and this made it difficult to manage him safely. His history of abuse had also left him with mental health problems. He was diagnosed with a personality disorder, depression and found it difficult to manage his moods. He was prescribed medication and was referred for psychological therapies. However, mental health specialists did not find evidence of psychosis or schizophrenia and concluded that he did not meet the criteria for the inpatient unit. The clinical reviewer concludes that the mental healthcare he received was generally appropriate.

The man also often said that he would die in prison and spoke openly about his frequent thoughts of suicide. As a result he was often managed under suicide and self-harm prevention (ACCT) procedures. When his level of risk was considered to be high, he was normally moved to the inpatient unit at the prison which, unsatisfactorily, is the only part of the prison with “safer” cells. Nevertheless, the investigation finds that overall he was adequately managed under the ACCT process, although some learning points are identified.

While there was no clear evidence to indicate that the man’s risk of suicide had risen in the days leading up to his death, a number of significant concerns emerge from the investigation. For example, the prison clearly lacks sufficient safer cells and this issue remains to be addressed even in these difficult economic times. It is also unacceptable that, on the day he died - and while still under ACCT procedures - staff unlocked, relocked and again unlocked his cell without checking on him. When finally discovered, he had been dead for some time, although misguided attempts were still made to resuscitate him.

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 **August 2013**

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SUMMARY

1. The man was remanded into custody in May 2011, charged with a number of burglaries and a robbery. He had been in prison many times before and said that he preferred life in prison to life in the community. He had a history of substance misuse and mental health problems and said that he had self-harmed in the past. He was initially prescribed methadone, which he stopped taking by February 2012. He was also prescribed anti-depressant medication. Mental health specialists who assessed him concluded that he probably had a personality disorder and depression but did not find signs of a serious mental illness such as psychosis or schizophrenia.

2. He often said that he would die in prison and spoke frequently about his suicidal thoughts. He was often monitored under suicide and self-harm prevention procedures (Assessment, Care in Custody and Teamwork, ACCT – explained later). He was subject to ACCT monitoring when he transferred to Manchester in November 2011. In February 2012, he received an indeterminate sentence, requiring him to spend at least three years and seven months in prison before he could be considered for release. Shortly after being sentenced, he said he would kill himself and was placed on ACCT monitoring again and moved to the prison inpatient unit.

3. The man had been abused as a child and consequently had a deep and open dislike for anyone he suspected of committing sexual offences or domestic violence. As a result, he was considered not suitable for sharing a cell. At times his potential for violence towards other prisoners made managing him in the prison difficult. While an inpatient, he was assessed by psychiatrists and referred to psychological therapies. He began working with a clinical psychologist and said that he benefited from the intervention.

4. In March, the man moved to a standard prison wing where he got a job as a wing cleaner and settled well. The ACCT monitoring ended in April, but in July, he said that his mental health was deteriorating and was prescribed a low dose of anti-psychotic medication by a psychiatrist.

5. In August, prisoners on the man's wing claimed that he was an informer and threatened to harm him. He was moved to another wing but the threats against him were not properly investigated.

6. On 6 September, the man said he had taken an overdose of prescribed medication and was taken to hospital. It is unclear whether he took the overdose but ACCT procedures were instigated once more. When he returned to the prison, he was given a cell in the inpatient unit again. While there, he had frequent contact with psychiatrists and mental health nurses. Because of his threats towards other prisoners, he spent most of the day locked in his cell. However, he said that he felt safe in the inpatients unit. He said that he had almost constant thoughts of suicide but would not act on them.

7. After a settled period in the inpatient unit, mental health specialists reviewed the man and concluded that he could be managed on a normal prison wing. In November, he was discussed at a multi-disciplinary case conference where it was agreed that he should be discharged from the inpatient unit. On 6

December, he moved to C wing. He was still being monitored under ACCT procedures.

8. C wing officers gave the man a job as a wing painter but he told another prisoner that he did not enjoy it and stopped after a few days. The other prisoner said that he told him he was struggling to cope and was thinking of self-harm. At an ACCT meeting on 11 December, officers thought he seemed positive and settled on the wing. Officers were instructed to record four conversations with him during the day and to check him four times at night.

9. A few days later the man was checked at 6.45am and was asleep. Although his cell was unlocked and locked three times between then and 12.17pm, he was not checked or spoken to until 12.22pm when officers realised he had not collected his lunch. He was found hanging in his cell and despite attempts to resuscitate him, he was pronounced dead at 12.40pm.

10. The man was a difficult to manage; he was open about his intention to kill himself but would only sometimes engage with the support and help on offer. Staff at Manchester were alert to his risks and to that extent his death was foreseeable. However, we have found no evidence of clear signs that his risk had risen in the days leading to his death.

11. We have identified some issues with the management of ACCT processes at Manchester and have also identified a need for cells with reduced ligature points on general prison wings. We are extremely concerned that the man was not properly checked on the morning he died, despite being still subject to suicide prevention procedures. We make eight recommendations about these matters.

THE INVESTIGATION PROCESS

12. The Ombudsman's office was notified of the man's death on 13 December 2012. An investigator was at the prison on another matter when he was found and spoke to staff involved in the incident. The investigation was allocated to another investigator. Notices were issued at Manchester informing staff and prisoners of the investigation and asking anyone who had relevant information to contact her. No responses were received.

13. The investigator obtained copies of the man's prison and medical records and other relevant documentation. She also viewed closed circuit television (CCTV) footage for the day of his death, of the landing on C wing where he lived.

14. The local PCT commissioned a clinical reviewer to undertake a review of the clinical care the man received at Manchester. Another clinician (on behalf of the clinical reviewer) and the investigator interviewed staff at Manchester in February and April. One prisoner, who had transferred to another prison, was interviewed by telephone. After the interviews, the acting Governor was given verbal and written feedback about our initial findings.

15. HM Coroner for Manchester City District was informed of the investigation and provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.

16. One of the Ombudsman's family liaison officers contacted the man's nominated next of kin, his sister, to explain the purpose of the investigation and invite her to raise matters she wished the investigation to consider. She learnt that he was being monitored under suicide prevention procedures at the time of his death and wanted to know who had conducted the last check and what they had observed. She said that she and the rest of his family were shocked that he had apparently taken his own life in prison. They thought that he was happier in prison than in the community and could not understand what had been different this time. They thought he had talked about feeling suicidal to staff. She asked if he had been bullied at Manchester and whether he should have been moved from the healthcare inpatient unit to a normal wing a few days before he died.

17. The final version of our report includes the National Offender Management Service (NOMS) response to our recommendations. We are very grateful to the man's family for considering the report at the draft stage. The comments they made have not resulted in any changes to the report and have been addressed in separate correspondence.

HMP MANCHESTER

18. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 male remand and sentenced prisoners.

19. At the time of the man's death, healthcare at the prison was commissioned by NHS Manchester. There is 24 hour nursing care and the healthcare centre includes an inpatient unit which holds up to 20 prisoners with physical or mental health problems. It is intended to provide mental health care to prisoners in crisis. In most cases, prisoners who are inpatients because of their mental health problems will stay in the unit until they can be safely moved to a normal prison wing. If their mental illness is severe, they might be transferred to an appropriate mental health facility. Nine of the inpatient cells are designated safer cells (explained below), although the windows in all of the inpatient unit cells comply with safer cell standards and have no window bars.

20. The inpatient unit is staffed by both general and mental health nurses. A psychiatrist holds clinics every week day and prisoners can also be referred to a psychologist or a counselling service. Prisoners who have mental health needs and are housed on a normal wing are seen by the mental health in-reach team.

Her Majesty's Inspectorate of Prisons (HMIP)

21. HMIP last carried out an inspection of Manchester in September 2011. HMIP's most serious concern was the high level of self-inflicted deaths at the prison, which was higher than most other prisons. The report says that while arrangements for caring for prisoners were not poor, there was room for improvement. The Inspectorate recommended that the prison focus more on learning lessons from previous deaths at Manchester and elsewhere. ACCT procedures were generally found to be better for prisoners in the inpatient unit than on normal prison wings.

22. HMIP were concerned about how incidents of violence and anti-social behaviour were dealt with. They recommended that an effective anti-social behaviour strategy be introduced that dealt with the root causes of poor behaviour, ensured that bullies were challenged and victims supported.

Independent Monitoring Board (IMB)

23. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their latest published annual report the IMB were concerned about the number of inpatients in the healthcare centre on open ACCT plans, which they said had reached unworkable levels. They noted that, following the most recent HMIP inspection, a cross-agency, cross-discipline task force had been set up to look at suicide prevention at the prison. They also noted that steps had been taken to ensure that case management was consistent.

Previous deaths at Manchester

24. Since 2009, there have been ten self-inflicted deaths at Manchester including the man's. We have previously made a recommendation about ensuring that ACCT documentation is properly completed and that community medical records are sought, which were issues in this investigation.

Assessment, Care in Custody and Teamwork (ACCT)

25. 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 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 be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves 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 of the actions on the caremap have been completed.

Safer cells

26. Safer cells have been specially designed to make the act of suicide or self-harm by self-strangulation or hanging as difficult as possible. This is achieved by reducing known ligature points as far as is possible and by installing specialist "anti-ligature" furniture and fittings. They are used for prisoners for whom the risk of suicide is deemed to be very high. While they reduce the likelihood of the prisoner being able to kill himself, they do not remove the risk altogether.

Personality disorder

27. A personality disorder is a mental health condition which affects how the individual thinks and feels. There are many different types of personality disorders, each with different symptoms. However, some of the more common symptoms include anxiety, depression, being emotionally "disconnected" and having difficulty maintaining close relationships. It is quite common for people with personality disorders to misuse substances.

28. Personality disorders are usually treated with long term psychological therapies (normally based around talking therapies). There is no licensed medication to treat personality disorders although some patients find medication such as anti-depressants helpful in managing some of their symptoms.

KEY EVENTS

29. The man was remanded into custody on 14 May 2011, charged with five counts of burglary and one of robbery. Initially, he went to HMP Altcourse but transferred to HMP Preston on 23 June. He had been in prison a number of times before.

30. He had a history of substance misuse and had been prescribed 25 millilitres (ml) of methadone each day by community drugs services. He also had some mental health problems, which mental health specialists linked to the sexual abuse he had suffered in the past. He said that he suffered flashbacks and saw the faces of his abusers around him, and as a result had violent thoughts about harming others. He described hearing voices coming from the radio and television. He had attempted suicide in the past and had voluntarily spent time in a psychiatric hospital. He said that he had been prescribed anti-depressants for many years but he did not think that they helped him to manage his feelings. His methadone and anti-depressant prescriptions were continued in prison.

31. During early assessments in prison, the man claimed to have killed several people, including one friend who he thought was a paedophile. (The police told the investigator that there was no evidence to link him with any murders.) He said that he heard the voice of this friend talking to him. He said that he wanted to spend the rest of his life in prison because he felt safest there and described himself as institutionalised. He said that he would kill himself one day. He said that he felt better when he was busy and had routine and so he was given a job as a prison cleaner.

32. In October 2011, as part of the court case, a psychiatrist carried out a psychiatric assessment of the man. He wrote that the man had a history of drug induced psychosis, anxiety, panic attacks, compulsive behaviour and suicidal thoughts. He told the psychiatrist that he had violent fantasies about killing sex offenders. The psychiatrist concluded that he did not have any clear symptoms of a psychotic disorder but probably did have a mild depressive disorder, post traumatic stress disorder and probably several personality disorders. He believed his reported visual and auditory hallucinations were linked to his coping strategies rather than a serious mental illness such as schizophrenia. He concluded that he was a high suicide risk.

33. The man transferred to Manchester on 10 November 2011. Preston emailed the Manchester safer custody team before he arrived to advise them that he had been monitored on an ACCT plan since August. Although he had not harmed himself, he said that he felt suicidal. The safer custody team was warned that he hated sex offenders and perpetrators of domestic violence. He was being checked twice an hour and was considered unsuitable to share a cell because of his risk to others. Preston advised Manchester that he did not like to have a television in his cell because it contributed to his hallucinations and increased his distress. He was due to be sentenced and staff noted that this might trigger his self-harm, depending on the outcome. On his arrival at Manchester, a nurse recorded that he was prescribed 15ml of methadone and 30 milligrams (mg) of mirtazapine (an anti-depressant).

34. During his first two days at Manchester, the man had appointments with substance misuse and mental health specialists. A substance misuse care plan was drawn up to manage his methadone prescription and he was placed on the list for discussion at the next mental health team meeting.

35. ACCT case reviews were held on both 10 and 11 November, attended by staff from a range of disciplines, including mental healthcare. The man said he had attempted suicide by hanging and overdose in the past but was not thinking of harming himself. He said that he would not harm himself for the sake of his children and grandchildren. He said that he did not get on with the staff at Preston and had wanted to create more work for them so had said he would harm himself. He said he had never felt suicidal at Preston. He said his main issue was with sex offenders. He was given a single cell on I wing (one of the detoxification wings) and staff were instructed to check him five times an hour overnight and to record in the ACCT plan at least four conversations with him each day.

36. The man was discussed at the mental health allocations meeting on 16 November, where it was decided that he would be best managed by the ACCT process but could access mental health care on a crisis basis. The ACCT plan was closed on 18 November, just eight days after his arrival at Manchester, when staff concluded that he had no thoughts of suicide or self-harm.

37. On 15 December, the man reported an increase in the frequency of his hallucinations, which he said were encouraging him to harm others. A mental health nurse assessed him that day and found no signs of a psychotic illness. He said that he was becoming agitated because other prisoners were coming to his cell. She agreed to arrange for him to move to H wing (the other detoxification wing), where he would be able to lock his own cell door and would be able to use the gym more easily. He moved to H wing the next day.

38. In February 2012, the man decided to start reducing his daily methadone dose. On 17 February, he was given an indeterminate sentence for public protection (IPP) with a minimum of three years and seven months to serve before he could be considered for release. He said that he had expected to receive a longer sentence. Staff thought he seemed angry on his return from court, but he said he had no thoughts of harming himself. On 22 February, he moved to C wing, which mainly holds prisoners with long sentences.

39. On 26 February, the man said that he would hang himself at the earliest opportunity. He said he had not taken his medication for three days and was seeing things coming from his radio. He seemed distracted and made little eye contact. As a result, he was moved to a safer cell in the healthcare inpatient unit and an ACCT plan was opened. He was told to alert staff if he felt like harming himself but he said that he would not tell them if he decided to harm himself.

40. At 9.00am on 27 February, one of the inpatient unit nurse managers carried out an ACCT assessment. She recorded that the man was angry about his previous mental health treatment and that felt he had not been listened to. He would not say what method of suicide he was considering but said he would do it at night time. He said that he had had enough, having spent half of his

life in prison. She decided that he should be constantly monitored in a gated cell (where the door is replaced by a gate so that staff can better observe the prisoner).

41. The ACCT case review took place 15 minutes later, attended by the nurse manager, two mental health nurses, a healthcare assistant and the man. The two mental health nurses had assessed him, who continued to talk about suicide and be preoccupied by his hatred for paedophiles. He asked for medication to help him manage his hallucinations but remained adamant that he would kill himself. An urgent referral was made to the prison psychiatrist. The nurse manager made two entries in the caremap, noting that he needed further assessment by the mental health team and that he should be placed in a safe environment and given time to talk.

42. The nurse manager told the investigator that the man was a sad character, who often said that he did not ever want to be released from prison and that he would die there. As an inpatient, he had a very limited regime, largely because he could not mix with other inpatients. She explained that the inpatient unit held a mix of prisoners, some of whom were sex offenders. He had made it clear that he would attack anyone he even suspected of being a sex offender. He was therefore not allowed to associate with or take part in exercise periods with other prisoners and was unlocked on his own. He said that he preferred not to have contact with other prisoners. Several healthcare staff said that they felt he gained little benefit from being on the inpatient unit, because the regime they could offer him was so limited and not consistent with his stated preference to be kept busy, have a job and use the gym.

43. A psychiatrist assessed the man on 28 February. The psychiatrist recorded that his hallucinations were worse when he was alone and bored. He said that he had felt low in mood since he moved from H wing to C wing. He said that he wanted to occupy his time with more activities. The psychiatrist concluded that he did not need to be constantly supervised.

44. Another ACCT review was held later that afternoon, chaired by another nurse manager on the inpatient unit and attended by the man and medical staff. No prison operational staff were present. The group agreed that he posed a raised risk to himself. He agreed to work with the psychiatrist and staff and said that he had no thoughts of self-harm. The constant supervision was ended, replaced by five checks an hour and he moved from the gated cell to a safer cell.

45. A psychiatrist assessed the man again on 1 March. A mental health nurse was also present during the assessment. He asked if he could move out of the impatient unit, back to a normal wing because he felt better and wanted to use the gym. He said he was bored and did not have enough to do. The psychiatrist concluded that there was no need to prescribe any other medication but advised him to take the mirtazapine as prescribed. The psychiatrist noted that the healthcare team should work towards him returning to a normal wing and to begin the process, the level of observations should be reduced. Although no ACCT review was held, the ACCT on-going record shows that the frequency of checks was reduced. The required frequency of the checks was not recorded in the ACCT plan but entries in the on-going record indicate that he was checked every few hours.

46. On 5 March, a psychiatrist assessed the man, who reiterated that he wanted to return to a normal wing. Although he seemed short-tempered, there were no symptoms of a serious mental illness. The psychiatrist agreed that he could move to a normal wing.

47. Later that day, the man and various staff met for an ACCT case review before his discharge from the inpatient unit. The group agreed that his risk was now low and he denied any thoughts of self-harm or suicide. He said that he responded best to routine and structure and found using the gym regularly helped him deal with stress, anger and frustration. A mental health nurse reported that she had been working with H wing staff and one of the prison's operational managers to prepare the wing for his return. The staff present agreed that he should be allowed to move to H wing and he did so that day. The level of checks was reduced to four conversations during the day and three observations overnight.

48. A nurse manager told the investigator that, when staff at ACCT reviews concluded that the man's risk was low, this was in the context of him speaking and thinking about suicide a lot. She said that the risk assessment process is highly individualised and based on how the prisoner presents at the time.

49. The next day, a Senior Officer (SO) chaired another ACCT review on H wing. The man, a mental health nurse and a representative from the Offender Management Unit attended. They agreed that his risk remained low and he seemed positive in mood. His caremap was updated to reflect that he needed structure and routine to keep him busy. The mental health nurse agreed to continue to work with him on the wing. The SO chaired another case review on 12 March, after the death of another prisoner at Manchester, and recorded that his risk remained low.

50. In March, the man began working with a psychologist. She told the investigator that at the time she was a trainee clinical psychologist working at Manchester under the supervision of the prison psychologist. She was involved in a research study called Prosper, working with prisoners at risk of suicide or self-harm. One part of the study involved participating prisoners completing a diary for six days, writing about their thoughts and feelings. They discussed their diaries each day with a member of the research team. A second element of the study trialled the use of cognitive behavioural therapy with participants who had recently felt or were feeling suicidal. (Cognitive behavioural therapy is a type of psychological intervention which aims to teach participants new ways to manage problematic feelings or behaviours. It is considered effective in helping those who suffer with anxiety, depression and some psychotic disorders, amongst other problems.)

51. The man was referred to the trainee clinical psychologist because he was on an ACCT, and he agreed to participate in the diary study. He also agreed to a period of brief psychological intervention with her in addition to the Prosper study. (Brief psychological interventions are designed to take place over a set period of time, usually weeks or months, to work on a specific mental issue.)

52. The man told the trainee psychologist that he found it helpful to write down his thoughts and feelings. He also said that he benefited from talking about his

diary entries. She said that she perceived his needs to include reducing and coping with his feelings of distress, which made him suitable for a short course of cognitive behavioural therapy. She said that he had never engaged in a psychological therapy before. During their sessions they focused on the nature of anxiety, depression and anger. She described him as keen to understand and manage his moods better.

53. The trainee psychologist said that, in her view, the man was tormented by his past experiences of abuse. She said that she did not see any signs of a psychotic disorder or severe mental illness, such as schizophrenia, while working with him. While she knew that he often talked about suicide to others, she said that he did not talk about it during their sessions.

54. Another ACCT case review was held on 28 March and the staff present agreed that the man's risk remained low. He said that his depression was always present and that he had some thoughts of self-harm but would not act on them. The ACCT plan was closed on 11 April when he said that he felt much better and was finding his involvement with the Prosper study helpful. He said that he had not harmed himself and enjoyed his job and using the gym. The goals on his caremap were considered to be met by his ongoing contact with mental health practitioners and the structured routine offered to him on H wing.

55. On 3 May, a member of the Offender Management Unit and a mental health nurse discussed the man's sentence plan. They recorded that he did not respond well to group work, partly because of his deep hatred for anyone he suspected of being a sex offender. They noted that he needed help to develop his coping strategies to help him manage change. They thought he would benefit from further counselling and psychological input before he could be considered for group work. He had been keen to transfer to another prison, but now seemed settled at Manchester and was thought to be making good progress.

56. On 7 May, another prisoner on the wing reported that he owed the man tobacco and was now frightened that he planned to harm him because he could not afford to repay the debt. There is no evidence that the allegation was investigated.

57. Later that month, the man told an officer that his son and daughter wanted to meet him after many years without contact. He said that he had something to live for and looked forward to meeting them after his release. During a meeting with the trainee psychologist, he said contact with his daughter was a positive step forward. They continued to work on his coping strategies.

58. On 25 May, the man requested an appointment with the mental health team. He said that the mirtazapine was not working and he wanted the dose raised. The mental health team was tasked to assess him. There is no entry in his medical record to show that he was seen by anyone from the mental health team in response.

59. On 17 June, the man asked a nurse from the substance misuse service if he could be prescribed methadone again because he was using subutex every day. (Subutex is another heroin replacement which is often traded and

misused in prisons. He was not being prescribed the medication.) He said that he had been using subutex for several months and the nurse referred him to the substance misuse specialist doctor. Two days later, he was assessed by another nurse from the substance misuse service and told her that he had used illicit subutex that morning. He said that he had started using drugs again when he had made friends with a prisoner and then had been shocked to discover what his offence was. (We do not know what the other prisoner's offence was.)

60. One of the substance misuse specialist doctors examined the man on 20 June. He said he had been using subutex for about four months and had recently asked his suppliers not to sell it to him anymore. The doctor agreed to prescribe 10ml of methadone daily to help him stop using subutex and noted that they would then consider beginning another period of detoxification.

61. The man continued to see the trainee psychologist frequently and they discussed how he might better manage his anger and intrusive thoughts. He said that he had begun to use some of the techniques he had been taught and was reading self-help books. He said that contact with his children gave him a focus and he was thinking about his future. He said that building relationships with his children was his primary focus.

62. On 12 July, the man had an appointment with another of the substance misuse specialist doctors and said that he wanted to begin reducing his methadone dose by 2ml each week. He said that he was determined not to relapse. The doctor agreed with his decision to begin the detoxification.

63. On 18 July, the man asked a nurse on the wing if he could see someone from the mental health team. He said that for the previous three weeks he had heard the voice of a man telling him to harm others and that only using the gym stopped it. The nurse told wing officers and arranged for the mental health team to review him. The next day, the mental health team manager assessed him. He described hearing voices coming from his radio even when it was switched off and said that he did not have a television in his cell because it "talked to him". He said that he did not need to be prescribed anti-depressants because he was not depressed.

64. The prison psychiatrist assessed the man on 20 July. He recorded that he was adamant that the anti-depressant medication was not working and that he needed other medication. However, he said that he had been feeling low for a long time. He could not explain the nature of the voices he heard, but said they came from all around him. The psychiatrist concluded that he had no symptoms of a major depressive disorder or of a major mental illness. He said that he was not thinking of harming himself and was thinking about his future and meeting his family. He appeared content with the contact he had with mental health services. The psychiatrist decided to prescribe him a low dose (150mg a day) of the anti-psychotic medication quetiapine, which can also be prescribed to help manage moods.

65. On 6 August, the man refused his methadone (he was now down to 2ml daily) and was given other medication to help him manage any withdrawal symptoms.

66. The man had a follow up appointment with a psychiatrist on 14 August and said that he was finding it easier to cope with his anger, impulsivity and the voices he heard. He thought this might be the result of taking quetiapine and learning new coping strategies with the trainee psychologist. He said that he had got rid of his radio but planned to start watching television again. The psychiatrist agreed to increase the dose of quetiapine to 300mg and arranged to see him again in eight weeks. The psychiatrist told the investigator that the slightly higher dose of quetiapine had a tranquilising effect and also could help him manage his irritability.

67. On 17 August, a member of staff completed a Security Information Report (SIR) because information had been received that the man might be at risk of harm from other prisoners. (An SIR must be submitted by any one working in a prison who has information which might compromise the safety of the public, prison staff or other prisoners, or the security of the prison. SIRs are dealt with by the prison's security department.) Information suggested that a number of prisoners on H wing thought that he was passing information to staff. The H wing manager was informed and so was the safer custody team. He was to be offered vulnerable prisoner status. (Prisoners can be classified as vulnerable for a number of reasons, including the nature of their offence, their ability to cope in prison or problems with other prisoners. Vulnerable prisoners are kept separate from the general prison population at Manchester.)

68. The next day, a SO, one of the H wing managers, was advised about the SIR and told to offer the man vulnerable prisoner status. The SO recorded that he was adamant he was not at risk. The SO also recorded that, given his feelings towards sex offenders (who are usually classified as vulnerable prisoners), it would not be appropriate for him to live on a vulnerable prisoner wing. He said that he would tell wing officers if he was concerned about the risk and signed a disclaimer confirming that he did not want to be treated as a vulnerable prisoner.

69. On 21 August, another SIR was submitted reporting that the man had a mobile telephone, which was being used by a number of prisoners on the wing. This was the first time there had been any information of this type about him and staff in the security department decided that he should be monitored for seven days.

70. The next day, the man's cell was searched and officers found a mirtazapine tablet hidden in his soap dish. The pharmacist confirmed that he did not have permission to keep the medication in his cell and so he was placed on a disciplinary charge. (On 24 August, he received seven days loss of association as a punishment for having the tablet.)

71. On 23 August, an anonymous note written by prisoners was found. The note warned staff that prisoners knew the man was passing information to officers and that, if he was not moved to a different wing very soon, he would be seriously injured. The authors of the note wrote that they knew he had been caught with drugs in his cell and that any other prisoner in that position would lose their cleaning job. They felt this was further evidence that he was an informer. The contents of the letter were logged on an SIR and both wing

staff and the safer custody team were informed. It was decided that he should be moved from the wing.

72. That morning, the man was told that he would be moved from the wing because of the threats. Another SIR was submitted which named two prisoners suspected of writing the note. He said that he had already spoken to them, but said that if he came into contact with either of them he would kill them. Both of the other prisoners had been suspected of making threats in the past. The security department decided that the three prisoners should be kept separate and the safer custody team was informed. He was moved to B wing.

73. The violence reduction officer told the investigator that it was generally the responsibility of wing officers to investigate allegations of violence or bullying. He explained that this was a documented procedure which normally involved interviewing the alleged perpetrator. If officers found evidence of anti-social behaviour the perpetrators could be placed on a monitoring system. Victims of anti-social behaviour can also be offered structured support, which should also be documented.

74. He said that, according to local tackling anti-social behaviour measures, the nature of the SIRs should have been discussed with the man (which they were) and suspected perpetrators should also have been interviewed and challenged. The investigator asked for any anti-social behaviour monitoring documentation where he was named as the victim. None was located, suggesting that the threats against him were not formally investigated. There is no evidence to suggest that the two prisoners named as responsible for the anonymous note were challenged about their involvement.

75. Later in the day, the trainee psychologist visited the man on B wing, who said that he wanted to get a cleaning job on the wing and settle into the routine again. He said that his offender supervisor had visited him and discussed whether he wanted to move to another prison. (It is not clear whether he did or did not want to transfer prisons at this stage.) She told the investigator that he did not seem too concerned about the threats and would have been happy to stay on H wing.

76. On 25 August, another SIR was submitted because the man was worried that prisoners on B wing were threatening to stab him because he was an informer. He feared for his safety and asked to be separated from other prisoners for his own protection. Staff noted that this would be difficult because he could not be placed with other vulnerable prisoners and that, for the moment, the best they could do was to keep him locked in his cell until a more suitable location had been found. Two days later, the security manager advised that he could be offered a move to A or E wings and that prisoners making threats should be dealt with under the violence reduction policy and the Incentives and Earned Privileges (IEP) scheme. (Under the IEP scheme, good behaviour is awarded with extra privileges, and poor behaviour results in some privileges being taken away.)

77. The trainee psychologist and the man met on 29 August and discussed how he felt about the threats. He said that prisoners were shouting at him from other cells that they thought he was an informer and he felt anxious and

reluctant to leave his cell. They talked about how he could use the strategies she had taught him to manage his feelings. He said that he had spoken to officers on the wing about how he felt, which was positive. He said he did not have any thoughts of self-harm or suicide. She told the investigator that she felt he was dealing with his situation as best he could and was using the strategies they had worked on together.

78. The trainee psychologist told the man that they had achieved the goals they had set for working together and that she would write an assessment and discharge report for him to summarise the work they had completed. She spoke to wing officers about him and they said that they were monitoring the risks of violence from other prisoners and his suicide and self-harm risk. She visited again on 3 September to give him his discharge summary. She said that as their work together had finished, she would discuss him at the mental health team meeting so that mental health staff understood his needs.

79. The man was discussed at the mental health team meeting on 4 September, which was attended by the trainee psychologist and mental health nurses, psychiatrists, a clinical psychologist and a representative from the substance misuse service. The group agreed that the mental health team would continue to offer crisis based support to him when he needed it. She agreed to visit him on the wing to reiterate that he could seek support from the mental health team if he needed it.

80. The trainee psychologist spoke to the man on 5 September and suggested that his mental health symptoms might return if he did not keep busy and engage with the prison routine. She also spoke to wing officers and told them to contact healthcare staff if he needed any mental health input. The officers said that they were monitoring him and speaking to him regularly. She told the investigator that he seemed to accept that their work together had reached a natural conclusion and agreed that he had achieved his goals. She said that he told her that he understood his emotions better and was happy to be discharged.

81. On 6 September at 2.20am, the man rang his emergency cell bell and told the night patrol officer that he had taken an overdose of medication. He was moved to the inpatient unit for monitoring while advice was sought. Healthcare staff decided that he should be taken to hospital. While waiting for an ambulance, staff opened an ACCT plan.

82. At hospital, the man said that he had taken an overdose of loperamide 2mg capsules which he had in his cell. (Loperamide is prescribed to treat severe diarrhoea or intestinal problems. He had been prescribed the medication on 6 August for diarrhoea.) He showed no signs of an overdose and he was discharged back to prison. As part of the investigation, we obtained the hospital notes. It is not clear whether he had actually taken an overdose, but his observations were normal and hospital staff agreed to discharge him within a few hours of his arrival.

83. The man returned to the prison at 8.30am, and was admitted to a safer cell in the inpatient unit. At 9.30am, a nurse manager carried out an ACCT assessment. He talked about the voices he said he heard and that he felt no one was listening to him or prescribing him the right medication. He said that

he had planned the overdose because he wanted to die and was not sure why he had alerted staff. He said that he had written a suicide note for his children. He told her that he felt worthless and dirty and wanted to stop the voices. He reiterated that he wanted to be dead but said he had no further plans to harm himself. He said that he was patient and, if he wanted, would wait for an opportunity to harm himself. He said that his family gave him support but he did not want it, and did not want them to see him in prison.

84. The nurse manager told the investigator that when she assessed the man after the possible overdose, she did not notice any change in his mood or behaviour, and did not judge his risk to have changed very much. She said "there never really was any difference with him. You never saw him happy… " As a result, she said it was difficult to assess his risk and staff checked his body language, level of eye contact and non-verbal indicators as well as what he said to help decide his risk level.

85. Twenty minutes later, mental health nurses and a psychiatrist met for the ACCT case review. The man was angry when asked about past mental health treatment and said that the medication he was prescribed did not help. The staff agreed that he posed a raised risk to himself and that he should remain in a safer cell. One entry was made on his caremap, noting that he needed to be assessed by the psychiatrist and reviewed on an ongoing basis. Monitoring was agreed at three observations overnight and two conversations during the day.

86. A mental health nurse and a psychiatrist assessed the man later that morning. He said he would harm himself if given the opportunity and thought about it all the time. He said that he realised that medication could help but would not erase his memories. He said that he felt better when he had talked about his problems. The nurse noted that his body language was poor during the appointment, that he was irritable and angry and did not want to talk about his mood or self-harm. He found it hard to maintain eye contact and seemed quiet and sad. He said that he had recently had to move wings because he had been set up by other prisoners, and so had lost his job. He said that he needed to be kept busy to keep his mind off his thoughts. He said that he had stopped taking quetiapine two days earlier because he did not think it was working. The psychiatrist advised him to keep taking the medication.

87. The man said that his plans for the future involved hurting as many paedophiles as he could and said he had tried to get vulnerable prisoner status to get closer to them. He said he did not want to return to B wing. The psychiatrist concluded that he had no symptoms of a major mental illness and that most of his symptoms were the result of him thinking about his past. A care plan was put in place to monitor his compliance with medication and to observe his mood and behaviour. Once again, he could only be unlocked when other inpatients were locked in their cells.

88. A nurse manager chaired a case review at 9.20am on 13 September attended by the man, two wing officers and a healthcare assistant. He said that he thought about harming himself every day but would not discuss whether he had made any plans to do so. The caremap was updated to reflect that he needed to be kept separate from other inpatients in case he tried to harm anyone. On 17 September, he began to ask about returning to a normal wing.

89. On 18 September, the man had an appointment with a psychiatrist. The psychiatrist recorded that he was settled on the unit and denied any thoughts of suicide or self-harm. He said that he felt more in control of his thoughts and actions. He said that he was not hearing voices and felt better since being prescribed quetiapine and working with the trainee psychologist. The psychiatrist wrote that he had no symptoms of major depression or a psychotic illness. He wrote that he seemed to be beginning to accept that the voices he heard were his own thoughts. He appeared to be thinking about the future and described his family as important. The psychiatrist decided that he should continue to be prescribed quetiapine at the same dose and arranged to review him in six weeks. The psychiatrist discussed him with a nurse and agreed that he could return to a normal wing.

90. A nurse manager chaired an ACCT case review on 20 September, also attended by the man, a mental health nurse and an officer. The group discussed him moving to K wing and noted that, unfortunately, no staff from K wing had been able to attend the review. They concluded that his risk level was low as he said that he had no thoughts of self-harm at that time. He was happy with the idea of moving to K wing and moved later that day. (K wing is usually reserved for remand prisoners.)

91. The next day, the man told wing staff that he would like a job on the wing as he did not think he could cope with the workshops due to his anxiety.

92. On 23 September, the man told an officer that he was not feeling too good. He said that he heard voices from the television and saw the faces of his abusers and those he said he had murdered. The officer asked if he thought about self-harm and he replied that he did so every day but that did not mean he would act on his thoughts. He said that he knew he could speak to staff if he needed to.

93. The next day, a SO ensured that all wing officers were aware of the officer's conversation with the man and instructed them to keep a close eye on him. Later that evening, he told another officer that a prisoner on the wing had called him an informer and that he now felt under threat. An entry was made in the wing observation book. He said that he would like to move to another prison.

94. At 9.15am on 26 September, a SO chaired an ACCT review, with the man, a SO, an officer and the Imam present. They agreed that he posed a high risk because his mood was low and he felt hopeless with nothing to live for. He said that he had made plans to hang himself. He told the staff that he was in contact with his daughter but did not want her to visit him. The mental health team was asked to assess him as a matter of urgency. In the meantime, he was moved to a cell near the staff office and his door was left open. Wing officers checked him five times an hour until he had been assessed by the mental health team.

95. A mental health nurse assessed the man later that morning. He spoke readily of his plans to hang himself and said it would only take him five minutes. He said that he had tried before. On one occasion, the belt he was using broke. On another, thoughts of his daughter stopped him. He made little eye contact

and said he had not eaten or taken his medication for two days. The nurse recorded that he seemed determined to kill himself and he had said that his family would understand. After her assessment she discussed him with a psychiatrist and they agreed he should be re-admitted to the inpatient unit and be seen by a psychiatrist that afternoon. At 11.50am, he moved to a safer cell in the inpatient unit.

96. On his arrival, a nurse, a locum psychiatrist, a general nurse and a mental health nurse held an ACCT review with the man. He said that he felt the only way out of his problems was to kill himself. He did not think his medication was helping but the psychiatrist concluded it was not appropriate to change the prescriptions. The psychiatrist noted that he was not psychotic but probably had a borderline personality disorder and an unstable mood. The psychiatrist thought that he would benefit from a longer period of counselling to deal with his childhood trauma. He was referred to the prison psychologist.

97. A mental health nurse chaired an ACCT case review on 1 October. A psychiatrist, a mental health nurse and an officer also attended, along with the man. Since his admission to the unit, he had been eating well and sleeping. He said that he was not keen to work with the psychiatrist because he did not like being told that the voices he heard were linked to his thoughts rather than hallucinations. He said that he felt better in the inpatient unit and did not want to return to a normal wing. He said he did not hear the voices while on the unit and denied any thoughts of suicide, however, he said that healthcare staff could not help him and only a transfer to another prison would. He said that he would harm himself if he was moved from the inpatient unit. The group decided that the observation level could be reduced to every two hours.

98. The next ACCT review was held on 8 October, chaired by a nurse manager, attended by the man, a mental health nurse, an officer and a general nurse. They assessed his risk as low. Although he said he thought of harming himself every day he said he could not harm himself in a safer cell (which is not necessarily true). The group discussed where he might move in the prison. He said that he needed structure in his daily routine and did not like being on a big wing. They decided that he no longer needed to be in a safer cell and he moved to a standard cell in the inpatient unit later that day.

99. A mental health nurse spoke to the man on 10 October. He said that he was all right and preferred to be in his cell, away from other people. He rated his mood as five out of ten. He told her that he wanted to move to B wing, but could give no reason for this. She recorded that he had said he could kill himself anywhere, except the inpatient unit. A nurse manager told the investigator that even when he was in a safer cell, he had other items in his cell that he could use to harm himself if he was determined to do so, including being given razors to shave, a television with a flex and bed sheets which could be used to make a ligature.

100. On 13 October, the Head of Safety and Equality at Manchester reviewed the man's ACCT plan and noted that staff needed to record more information about their conversations with him.

101. A psychiatrist assessed the man on 16 October. He said his mood was unchanged and he did not want to move to a normal wing, although he said

he would like to return to his job as a wing cleaner. He told the psychiatrist he was taking his medication as prescribed and was sleeping and eating better. He denied thoughts of suicide but said he would kill himself if he was discharged from the inpatient unit. The psychiatrist concluded that there was no clinical reason for him to remain an inpatient but, due to his threats that he would kill himself if discharged, decided that a case conference meeting should be arranged to discuss him and agree a discharge plan. The psychiatrist spoke to the inpatient manager, who agreed to arrange the case conference.

102. The case conference took place on 23 October. The man was not the only prisoner discussed at the meeting, which was attended by representatives from general healthcare, mental healthcare, safer custody and other relevant departments. His Offender Supervisor and a psychiatrist were both present. The group agreed that there was no clinical need for him to remain an inpatient and that he should be told that he would be moving back to a normal wing. When interviewed, the Offender Supervisor said that she knew he felt more comfortable on the inpatient unit but that was not sufficient reason to keep him there and he could be adequately managed on a normal wing.

103. The Head of Safety and Equality at Manchester told the investigator that there were no safer cells on the normal prison wings. She said prison managers had recognised that this sometimes meant that prisoners on ACCT plans, particularly those on high levels of observations, were moved to the inpatient unit when they did not have a clinical need to be there. She said that the prison had recently bid for additional funding to change some cells across the prison to safer cells.

104. She said that the decision to place someone in a safer cell should be based on the risk assessment and was generally a response to a period of crisis. She said that prisoners should not be given safer cells for long periods of time. She said that ideally, when the man moved from inpatients to a normal wing, he would have spent some time in a safer cell on the wing, to give him extra support. She said that she thought C wing was a suitable wing for him to move to because it was quieter and settled and he would be able to engage in prison activities.

105. A mental health nurse and the man met on 25 October. He rated his mood as two out of ten but repeated that he could not kill himself in a safer cell. He said that he felt safe in the inpatient unit. She recorded that he sometimes felt paranoid and thought he heard other prisoners call him a ‘nonce’ (a prison term for a sex offender against children) but could not tell if this was real or not. The nurse wrote that he rejected the idea that the voices he heard were the result of his thoughts.

106. A nurse manager chaired an ACCT case review on 27 October, attended by the man, a mental health nurse, a healthcare assistant and an officer. The nurse manager noted that the Head of Safety and Equality’s view had been sought during the case conference meeting on 23 October. The staff assessed his risk as low. He said that he still did not want to move to a normal wing because he would feel afraid. He described feeling like harming himself all of the time but that thoughts of his children prevented him. However, he said that he had not heard from his children recently and this

worried him. She agreed to contact the prison chaplaincy to see if they could help him contact his children. The nurse added that information to his caremap. She recorded that the level of observations remained unchanged. It is not clear from the front cover of the ACCT plan what the observation level at this point was expected to be, but entries in the on-going record indicate that staff were recording five conversations with him during the day and he was being checked four times at night.

107. On 6 November, the nurse manager chaired another ACCT review, attended by the man, general nurses, mental health nurses and an officer. They concluded that his risk remained low although he said he felt low in mood because it was a significant date for personal reasons. He said that the chaplaincy was helping him to contact his daughter. He again described constant thoughts of self-harm, but said he would not act on them for the sake of his family. He was offered the chance to talk about how he felt but said he did not want to. The level of observations remained unchanged.

108. A mental health nurse assessed the man on 20 November and found him suitable for a normal wing, although she noted that it was difficult to find a suitable wing for him due to his risks to himself and other prisoners. Although she observed no signs of low mood, he said that he always felt low and anxious. He said that he still wanted to kill himself, and if he was given the chance would do so.

109. That afternoon, a mental health nurse chaired an ACCT review at which the and various staff were present. The review discussed where he might move to in the prison and he said that he would like to be placed on a small wing. He continued to say that he would attack any prisoner he thought was a sex offender. The staff tried to discuss his anger with him, but he refused. He said that he wanted to move to another prison. He said he was willing to engage in counselling and would not act on his thoughts of self-harm.

110. The man's Offender Supervisor referred him for counselling on 23 November. On the referral form she noted that he had tried counselling before and could not manage group settings, but would try one-to-one sessions. He was placed on the waiting list for assessment.

111. The Offender Supervisor told the investigator that she knew that the man often talked about suicide but felt that his risk was likely to be highest when he was due for release. She said that, in her view, that was not likely to be for a number of years because he generally refused to engage in work to address his risk of re-offending. She said that he requested a transfer to another prison but could not identify any particular prison that he wanted to move to. She said that she explained to him that it would be much easier to arrange a transfer if he agreed to engage in counselling and courses, and worked to come off the ACCT plan. She said that she was not convinced that he really wanted to transfer to another prison

112. On 27 November, the man had an appointment with two psychiatrists. Psychiatrist A told the investigator that Psychiatrist B asked him to assess whether the man could move to a normal wing and to consider whether anything else could be done to reduce the risks he posed. Before meeting him, he discussed him with nurses and Psychiatrist B, who told him that he

was eating and sleeping normally, had not tried to harm himself or others and was not showing any signs of a psychotic illness. They told the psychiatrist that he was not in a safer cell but that he had said he would harm himself if he was moved to a normal wing.

113. During the assessment, the man said that he wanted to kill himself and would do it "a million per cent". He described feeling hopeless and said his triggers to self-harm were thinking about the abuse he had suffered and watching certain television programmes. He said that he could normally distract himself by reading books and turning off the television. He would not discuss whether he had made a plan to kill himself and was dismissive of the psychiatrists' questions about whether he was experiencing any hallucinations or hearing voices. He said that the prescribed quetiapine was helping him to sleep but not changing his thoughts.

114. The man said that he was not bothered whether he stayed in the inpatient unit or moved to another wing. The psychiatrist noted that he was sometimes uncooperative and irritable during the appointment and appeared disinterested. The psychiatrist concluded that there was no evidence that he had a major psychiatric condition but that he did have a persistent low mood as a result of his past history, as well as traits of an emotionally unstable personality disorder. The psychiatrist told the investigator that signs of this type of personality disorder include a fluctuating mood, impulsivity, thoughts of self-harm but an unwillingness to accept help, and that he was displaying all of these signs. He wrote that he clearly posed a risk to himself and to others. However, he concluded that he should not remain on the inpatient unit because there was no clinical need for him to do so. The two psychiatrists agreed that the management plan should be to continue to prescribe quetiapine, to liaise with psychological services to continue the work begun by the trainee psychologist and to discuss how staff could manage his risk once he was on a normal wing.

115. The psychiatrist told the investigator that psychological interventions are considered to be the best way to manage personality disorders and related issues, but rely on the patient engaging with the treatment. He said that there was no medication which could cure problems such as those the man experienced, although medication could help him to control some of the symptoms. He said that, had he not been in prison, it is likely that he would have been managed in the community, rather than in hospital. He also did not think that he needed to be in a safer cell because he had been in a normal cell for a period of time and had not harmed himself.

116. According to the man's telephone record, he last tried to contact his daughter by telephone on 27 November but there was no answer. It seems they had not spoken since August although he had tried calling on several occasions since then.

117. On 6 December, the man and several staff met for an ACCT review. They agreed that he still posed a raised risk to himself but that his situation had been discussed with the psychiatrists and prison managers who had agreed that in the absence of a clinical need for him to remain an inpatient, he should move back to a normal wing. They noted that he continued to say that he would harm himself if he was discharged from the inpatient unit. A SO had

been fully briefed about his risks, his history of abuse and his feelings towards sex offenders. The mental health team had agreed to continue to support him on C wing and a psychiatrist was due to review him in two weeks. The observations level was agreed at five conversations during the day and four checks during the night. The review did not record when conversations were expected to take place.

118. A SO walked the man to C wing at about 10.45am on 6 December and showed him to his cell on the top landing of the wing known as the "4s". Officers interviewed as part of the investigation described C wing, which held around 124 prisoners, as a settled wing, mainly because the majority of prisoners living on the wing were serving long sentences. They said that the number of prisoners on ACCT plans on C wing tended to be very low. Most thought that it was the most appropriate wing for him to live on, bearing in mind his needs and vulnerabilities.

119. The SO asked an officer to be the man's personal officer and he introduced himself to him shortly after he arrived on the wing. The SO thought the officer would be a suitable personal officer for him because he was calm, supportive and would be able to help him settle on the wing. The officer knew that he was on an ACCT (although he said he had not had time to read it) and was coming to the wing from the inpatient unit. He asked the officer to help him get a job on the wing.

120. Over the next few days, C wing officers recorded their conversations with the man in the ACCT ongoing record. They noted that he was keen to get a job on the wing and on 9 December, he was offered a job on the wing painting team, which he seemed pleased with.

121. After the man's death, Prisoner A, another prisoner then living on C wing, submitted a complaint form, complaining that he had warned officers that he would kill himself and they had not cared. The investigator spoke to him and he said that he had got to know him a little because they were both working as wing painters. The prisoner, who had been at Manchester for some time, said that he had never heard his name mentioned before he met him and he was unaware of any allegations of him being an informer or the target of bullying.

122. Prisoner A thought that the man seemed a bit low. After a couple of days as a painter, he said he told him that he did not want to continue with the job as he felt paranoid around people and in open spaces. He said that he told him he was feeling depressed and was struggling. He said that he asked him about where to get razor blades and talked about cutting himself. It is not clear exactly when he resigned from his job as a wing painter.

123. On 11 December, a SO chaired an ACCT case review, attended by the man and an officer. A mental health nurse had come to the wing earlier in the day, expecting to attend the review but the time had been changed without notice. She could not attend the rescheduled review in person but, according to the ACCT plan, discussed him with the SO over the telephone. The SO recorded that his risk was still raised but that he had settled well on C wing. He said that he did not like being in crowds of people and so spent much of his time in his cell. They discussed whether he might be interested in attending the day

centre run by the mental health team, where he would mix with only a small group of prisoners and help address some of his anxieties. The nurse agreed to assess his suitability for the day centre. The SO recorded that he reiterated that he needed routine and that she was keen to ensure this was provided. She changed the observation level to four recorded conversations during the day and four checks during the night. She did not specify when she expected the conversations to take place. She arranged the next review for 21 December and the nurse agreed to attend then.

124. The SO told the investigator that the man talked about his future and seemed much better than at the last case review. She thought that they had made some progress with him and that his risk had reduced a bit, although she still considered the risk to be raised. She said that, in setting the observation level, she anticipated that staff would have contact with him throughout the day, but particularly at unlock (about 7.40am), at lunch time, at afternoon unlock and at tea time.

125. Prisoner A said that he spoke to the man again on 12 December and that he said he was not feeling good and "could not do this anymore". He said that he was concerned about him so he went to speak to an officer, who was just about to leave the wing. At interview, the prisoner said that he told her he needed to speak to her urgently, but she said she did not have time to speak to him. It was unclear whether he had explained why he needed to speak to her or not when she allegedly told him she did not have time. She was interviewed after the draft investigation report was issued. She said that she could not remember being approached by him, but that if he had asked to speak to her, she would have listened. She said that she took concerns about suicide or self-harm very seriously. She said that she knew the man was on an ACCT plan.

126. Prisoner A said that he then went to speak to the SO who was in the wing office. He said that he realised she was writing in an ACCT plan, which he assumed was the man's. He said that he thought that meant staff were already dealing with him and so he did not tell her about his conversations with him. He did not share his concerns with any other officers or prisoners.

127. The closed circuit television (CCTV) footage covering the 4s landing on C wing, on 13 December, shows that an officer checked the man at about 6.45am and he recorded that he was asleep. He did not have a job (having left his job as a painter) or attend education, and so stayed on the wing all day.

128. At 7.50am, a female officer unlocked all of the cells on the 4s landing, including the man's. She did not look through the observation panel in the cell door as she unlocked each door. He did not come out of his cell while it was unlocked. At 8.40am, cell doors on the 4s landing were locked again by a male officer. Again, the officer did not look into his cell while locking the door. No staff looked into his cell during the morning and he did not press his emergency cell bell.

129. The SO who was in charge of C wing on the morning of the incident told the investigator that he had not had very much contact with the man since he

moved to the wing and knew little about his history, although he said that he would have read his ACCT plan as a matter of course.

130. The SO said that at the morning management meeting attended by senior officers and operational managers he had asked if any additional staff could be deployed to C wing. He said that some of the C wing officers had noticed an atmosphere on the wing and were concerned that some prisoners were planning to cause trouble. He was told that there were no available staff to help. He told the investigator that C wing was short staffed during the morning period because several C wing officers had duties in other parts of the prison. As a result of the concerns and the shortage of staff, prisoners who were not at work or education were locked in their cells for the morning. He said that, during the morning, he had to deal with a disagreement between two officers and a problem with a prisoner who was being moved off the wing. Because of the issues on the wing, the daily cell check (which involves checking that that the fabric of the cell, including the door lock and window bars, has not been damaged in any way) did not take place. At lunch time, he decided that one landing at a time would be unlocked to collect their food. It seems that no one officer was given the task of carrying out the man's ACCT checks.

131. The Head of Safety And Equality told the investigator that, in her view, as the ACCT observation level for the man was four conversations a day, he should have been checked during the morning period. She said it was the wing senior officer's responsibility to ensure that prisoners on ACCT plans were checked. The SO said that as his observation level was four conversations during the day, he expected officers to make sure one of these took place over the lunch period. He said that he would not have expected officers to check him between 7.00am and 11.30am. However, he said that, had the cell fabric check been carried out that morning as normal, he would have been automatically checked then.

132. Officer A returned to C wing from other duties at about 11.50am. At 12.17pm, he and the SO unlocked all of the cells on the 4s landing for lunch. The officer monitoring the servery asked him to check the man because he had not collected his lunch. The fficer returned to the cell at 12.22pm. He told the investigator that he looked through the observation panel in the cell door and could not see anyone in the cell. He went into the cell and saw him behind the privacy curtain which separates the toilet area from the rest of the cell. When he pulled back the curtain he saw him hanging from a bed sheet attached to the window bars. The officer called for help from colleagues and supported the weight of his body until other officers arrived. He used his anti-ligature knife to cut the bedding from the window bar and then from around his neck.

133. The officer told the investigator that the man's legs would not straighten when he was lowered to the floor, which indicated that rigor mortis had set in. (Rigor mortis is the natural stiffening of the body which normally occurs several hours after death.) The officer said that he was very cold to the touch and there were no signs of life. Two officers arrived at the cell very quickly and, despite the signs of rigor mortis, they began to attempt cardiopulmonary resuscitation (CPR, the delivery of chest compressions and rescue breaths to pump oxygen around the body). The SO radioed for healthcare staff to attend

and requested that an ambulance be called. The control room log shows that the ambulance was called at 12.24pm. One of the wing officers brought the wing automated external defibrillator (AED, which can deliver electric shocks to re-establish a normal heart rhythm in some circumstances) to the cell and it instructed them to continue CPR as his heart had no shockable rhythm.

134. Three nurses, the prison doctor and a student doctor arrived at the man's cell at 12.25pm and took over the CPR attempts. One nurse told the investigator that rigor mortis was present but that at Manchester the practice is that CPR is attempted until the paramedics arrive. She said that the prison doctor was quite new to the prison and did not want to pronounce death until the paramedics had arrived. The prison doctor no longer lives in the United Kingdom and so we were not able to interview him.

135. The ambulance arrived at about 12.31pm and, according to the CCTV, the paramedics reached the cell at 12.38pm. At 12.40pm, the prison doctor pronounced that the man had died.

Contact with the man's family

136. An officer was appointed as the prison family liaison officer (FLO). The man's nominated next of kin, his sister, lived in Darlington, approximately two and half hours journey from Manchester. Prison Service guidance on contact with a bereaved family suggests that, where the family live some distance from the prison, staff can either choose to travel to the family to break the news themselves or can ask a more local prison if their family liaison officer could break the news of the death instead. In some situations, it is preferable for a closer prison to do so as it can mean the family are informed of the death more quickly and before they learn of it from other sources.

137. After the man's death, HMP Frankland, a prison on the outskirts of Durham, was contacted and two of their family liaison officers agreed to visit the man's sister and inform her of his death. The FLO could not recall who decided to ask Frankland to break the news. The Frankland family liaison officers reached her house at 5.20pm, about four and a half hours after his death.

138. The FLO telephoned the man's sister the morning after the incident. During the conversation she invited the family to visit the prison if they wished. In line with national guidance, the prison offered to help with the cost of the funeral.

Support for prisoners and staff

139. C wing staff said that prisoners on the wing were told that the man had died and were offered support from officers, the chaplaincy team and Listeners (prisoners trained to offer a confidential listening service). All prisoners being monitored as a risk of suicide and self-harm were reviewed in case they had been adversely affected by his death.

140. All of the staff interviewed said that they had been well supported by the prison after the man's death. Those directly involved with the emergency response attended a meeting that day, chaired by the Head of Safety and Equality, during which they were offered further support and given an opportunity to talk about the incident.

Post-mortem report

141. The post-mortem report indicated that the man died as a result of hanging.

ISSUES

Treating the man's mental health problems

142. A clinical reviewer reviewed the mental healthcare the man received at Manchester. He agrees with other mental health professionals' assessments of the man, stating that, in his opinion, there was ample evidence that he had a borderline personality disorder. He agrees that some of his reported symptoms, such as hallucinations and hearing voices, were most likely the result of his early experiences of sexual abuse rather than a psychotic illness.

143. The clinical reviewer writes that the prescription of anti-depressant and anti-psychotic medication was appropriate. He also notes that the man was appropriately referred for counselling and, with the trainee psychologist at least, engaged well. He writes that the approach to his care was properly multi-disciplinary, involving psychiatrists, psychologists and general and mental health nurses.

144. The man had twice spent time in a psychiatric hospital (once in 2002 and again in 2009), both times were voluntary admissions. The clinical reviewer finds no evidence to suggest that any of the prisons that held him during his last period of custody requested his community psychiatric record, although healthcare staff were aware of his previous contact with psychiatric services. He notes that such records can be a useful source of information. We make the following recommendation:

    The Head of Healthcare should ensure that community mental health records are requested for all prisoners with mental health problems.

145. Psychiatrist A, who assessed the man in November, said that the man's mental health problems might well have been best addressed by psychological therapies alongside his prescribed medication. The man said he had benefited from his work with the trainee psychologist but, once that ended, was inconsistent about whether he would engage with counselling or other psychological therapies. Healthcare professionals continued to suggest and refer him to such interventions and, at the time of his death, he was on the waiting list to see the prison psychologist. His Offender Supervisor had also referred him for counselling.

Discharge from the inpatient unit

146. When the man's risk was deemed highest, he was placed in a safer cell in the inpatient unit, but once the risk was perceived to have reduced, he was moved to a standard cell on the unit. He was also successfully managed in a standard cell on a general wing for periods of time. He was discharged from the inpatient unit and moved to C wing on 6 December, a week before he died.

147. Before the decision to discharge the man was made, he was assessed by two consultant psychiatrists and was discussed at a multi-disciplinary case conference attended by general and mental health staff, representatives from the prison's safer custody team and his offender supervisor. Mental health specialists agreed that he did not have a serious mental illness requiring

specialist treatment on the inpatient unit. Because he was open about his hatred for and desire to harm those he thought were sex offenders or perpetrators of domestic violence, he could not participate fully in the regime on the unit. Staff described the limited regime he was allowed, which involved him remaining locked in his cell for most of the day. He was not allowed to mix with other prisoners or attend unit based activities. He said that he preferred to be kept busy and liked to work in prison. This was not possible while he was an inpatient. Against this, he said he felt safe on the unit and was reluctant to move back to a normal wing. Nevertheless, as there was no clinical need for him to remain an inpatient, it was decided that he should be managed on a normal wing. We agree that, on the basis of the evidence provided, he did not need to remain an inpatient and the decision to move him to C wing was appropriate. We discuss the matter of safer cells later.

Assessing and managing the man's risk of self-harm

148. During his time at Manchester, the man repeatedly said that he would kill himself in prison. He was open about often thinking of self-harm and suicide and, for the majority of the time, he was managed on an ACCT plan and his level of risk was often considered to be raised or high. The last ACCT plan was opened on 6 September and was still in place when he died. Because staff perceived his risk to be high, he spent more than one period in the inpatient unit principally because that was the only area of the prison where there were safer cells.

149. We have found that, generally, the ACCT process was adequately managed. While the man was an inpatient in the healthcare centre, his case reviews were managed by three nurse managers, although not all of them were as multi-disciplinary as we would expect to see. When he moved to a standard prison wing, the case reviews were chaired by one of the wing senior officers. Many of the case reviews involved general and mental health specialists, and psychiatrists also attended several reviews. His Offender Supervisor attended only one review, but told the investigator that she had been involved in ongoing discussions about his risk and felt sufficiently informed about his progress.

150. The ACCT caremap was updated when new issues were identified, although some of the entries on the caremap focused on how the man should be managed, rather than reflecting truly supportive goals to help him cope with his emotions. However, his suicidal thoughts were constant and not related to specific issues that could be easily resolved. He was also inconsistent about what most helped him to deal with his feelings. Sometimes he said that he needed to be kept busy, but then said he preferred to remain an inpatient where he spent most of his time locked in his cell. When he was given a job on C wing he gave it up very quickly.

151. Completion of the ACCT paperwork was generally adequate. However, after one of the 12 case reviews, the case manager at that review did not indicate the man's perceived level of risk. Case managers should also complete the front of the ACCT plan to indicate when the next case review is due and what the current level of observations is. The front of his last ACCT plan only details three case reviews and it is not always clear how frequently staff were expected to check him and record their interactions with him. This is possibly

because, while an inpatient, he was subject to regular checks outside the ACCT process, but the frequency of checks should always be recorded clearly on the front of the plan.

152. On 11 December, two days before his death, a SO chaired a case review and adjusted the level of observations to four conversations a day and four checks over night. Before that, officers were required to record five conversations with him each day. According to Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), staff must actively engage with a prisoner on an ACCT plan, encouraging him to talk and must record details of their conversations accurately in the on-going record. It is not always clear from entries in the on-going record whether staff had a conversation with him or merely asked how he was. Some interviewees described him as difficult to engage in conversation, and we appreciate that this might be the case with many prisoners on ACCT plans. However, it is important that staff record when they have actively tried to converse with the prisoner. As the PSI notes, "a good-quality, meaningful entry can communicate more than pages of meaningless comments".

153. On 13 December, the ACCT shows that the man was checked at 6.00am and 7.00am and both times the ACCT entry noted that he appeared to be asleep. This check is shown as being made on the CCTV at 6.45am. He was not checked again until 12.22pm when officers realised he had not collected his lunch. The SO who was responsible for C wing that morning, said that she would not have expected officers to check him until lunch time. She did not specify when she expected officers to conduct and record the ACCT conversations (other than to say they must take place during the day time). It is unsatisfactory that this should be open to such wide interpretation. In our view, in order to meet the objective of providing support to him throughout the day, at least one of the conversations should have taken place during the morning period. We note that the day before, December 12, a manager made an entry in the ACCT at 10.30am that observations needed to be up to date as there were no conversations recorded that morning. The previous day, December 11, there was a recorded conversation with him at 8.45am. We are not satisfied that observation and conversations took place as intended. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff complete ACCT plans correctly and in line with guidance and that the required level of observations and interactions are clear and specific.

154. A SO (who was ultimately responsible for ensuring that ACCT checks took place that morning) did not nominate any particular member of staff to be responsible for undertaking the man's ACCT checks and, as a result, none of the officers on duty did so. We make the following recommendation:

The Governor should ensure that wing managers make clear to officers at the start of each shift, who is responsible for conducting ACCT checks and observations and when they should be done.

Checking prisoners at unlock

155. On the morning of the incident, the man was checked by an officer at around 6.45am and was asleep. His cell was unlocked at 7.50am, locked again an hour later and unlocked for lunch at 12.17pm. None of the three officers looked into any of the cells as they unlocked or locked the doors. He was found hanging in his cell at 12.22pm.

156. Manchester has no local policy setting out what officers are expected to do when unlocking cells. The acting Governor said that it was good practice, but not mandatory, for officers to look into the cell before unlocking. The SO said that he did not expect C wing officers to do so, and the CCTV footage shows they do not. In our view, it was neglectful that none of the officers responsible for locking or unlocking the man's cell that morning thought to check him as they did so. He was on an ACCT plan because he was identified as at risk of suicide and self-harm and the purpose of the ACCT process is to provide extra support. When he was found, there were already signs of rigor mortis, suggesting that he had been dead for some time. It is not possible to say when he died, but had one of the officers unlocking or locking his door that morning looked through the observation panel as they did so, or interacted with him, he might have been found earlier or even saved.

157. For their own safety, officers are supposed to look at and make contact with a prisoner through the observation hatch before opening a locked cell door. As well as a security precaution, it is also supposed to be a check on the prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

158. While the wellbeing of all prisoners should be checked at unlock times it is particularly reprehensible that this was not done for someone on an open ACCT. We make no particular criticism of the individual officers as the acting Governor and wing managers agreed this was the accepted practice at Manchester. For that reason we have not interviewed them as the CCTV shows clearly that there was no interaction in line with the routine at Manchester. We make the following recommendation:

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Safer cells

159. The man was sometimes given a safer cell in the inpatient unit and, when in such a cell, said that he could not harm himself. If a prisoner is determined, it is entirely possible for him to harm or kill himself in a safer cell and we have investigated self-inflicted deaths of prisoners in safer cells. However,

Manchester does not have any safer cells on any of the general residential prison wings. Healthcare staff who were interviewed felt that some prisoners were moved to the inpatient unit because they needed a safer cell, rather than because of any clinical need. The purpose of the ACCT process is to ensure that prisoners at risk of suicide or self-harm can be safely and appropriately managed by officers or nurses. It is not always necessary or appropriate for someone at high risk of suicide to be moved from a wing where they are familiar with staff and other prisoners to be managed in the healthcare centre.

160. There is no certainty that, had there been an available safer cell on an appropriate wing, the man would have been allocated it on his discharge from the inpatient unit on 6 December as he had been living in a standard cell on the inpatient unit for some time by then. However, even the standard cells in the healthcare centre do not have accessible window bars. Had safer cells been available throughout the prison, staff could have considered allocating one to him as part of his discharge plan as a step down from the protective environment of the inpatient unit. In November 2012, Manchester bid for additional funding to convert a small number of cells on the residential wings to safer cells. We would support such provision and make the following recommendation:

The Deputy Director of Custody for High Security should ensure that some safer cells are provided at Manchester on standard residential prison wings.

The emergency response

161. The officer raised the alarm as soon as he saw the man hanging in his cell. Other officers responded quickly and began CPR promptly. The wing defibrillator was quickly brought to the cell and we are pleased that officers felt confident about using it before healthcare staff had arrived. Nurses, a student doctor and one of the prison doctors reached the cell within three minutes of hearing the radio alarm.

162. We are surprised by Manchester's policy to attempt CPR in all circumstances until the paramedics arrive, even when there are no signs of life and rigor mortis is present. This is all the more surprising given that, on this occasion, a prison doctor was also present at the scene but was apparently reluctant to pronounce that the man had died. European Resuscitation Guidelines 2010 state "Resuscitation is inappropriate and should not be provided when there is clear evidence that it would be futile …" Delivering CPR in such circumstances is distressing for staff and undignified for the deceased. It should not be necessary to certify death in order to decide it is not appropriate to attempt CPR. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

Responding to information that the man was being bullied

163. While at Manchester, security information indicated that the man was both the victim and, to a lesser extent, the perpetrator of bullying. Several SIRs were

submitted in August 2012 which suggested that he was at risk because prisoners thought he was an informer. An anonymous note to this effect was given to staff and a subsequent SIR named the two prisoners thought to be responsible for the note. Wing officers and the trainee psychologist talked to him about the threats, which he said he knew of but was not worried about. He was not offered vulnerable prisoner status because he had made clear his feelings about sex offenders, who make up the majority of the vulnerable prisoner population. He was moved to a different wing but, for a while, perceived that the informer label had followed him there. However, there is no evidence that he was being bullied or intimidated on C wing in the days before his death.

164. Nevertheless, it seems that none of the allegations were formally investigated as they should have been under the prison's violence reduction policy. There is no evidence that the two prisoners thought to be responsible for the anonymous note were interviewed or challenged about their behaviour or that any serious investigation took place. We make the following recommendation:

The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously and dealt with in line with local and national policies.

Breaking the news of the man's death to his family

165. The man was pronounced dead at 12.40pm and the prison family liaison officer was appointed shortly after that. At some point, a decision was made that staff from Frankland would be asked to break the news of his death to his family in Darlington. Manchester's appointed family liaison officer could not recall how the decision to ask Frankland was made, or by whom, and we do not know exactly what time Frankland agreed to help. However, the Frankland family liaison officers did not arrive at the man's sister's house until 5.20pm, over four and a half hours after his death.

166. The purpose of asking a geographically closer prison to break the news of a death to the family is because it is anticipated that they will be able to do so more quickly. PSI 64/2011 notes that "time is of the essence" to ensure that the family does not learn the news from another source. We do not consider that two and a half hours is an unreasonable journey time. Staff from the prison where the prisoner died are likely to have more accurate and detailed information to give bereaved families, and where possible, should notify the family of the death. In this case, we consider that his family would have learnt of his death more quickly if staff from Manchester had travelled directly to Darlington themselves. We make the following recommendation:

The Governor should ensure that where possible staff from Manchester should visit the next of kin in person to break the news of a death unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.

RECOMMENDATIONS

The NOMS response is provided in italics beneath each recommendation.

1. The Head of Healthcare should ensure that community mental health records are requested for all prisoners with mental health problems.

   NOMS accepted this recommendation: "The prison already have access to Amigos, the IT system for community records for Manchester Mental Health and Social Care Trust. This is on a read only basis. If a prisoner is out of the area and identified to us we will request those records from the community.

2. The Governor and Head of Healthcare should ensure that staff complete ACCT plans correctly and in line with guidance and that the required level of observations and interactions are clear and specific.

   NOMS accepted this recommendation: "The new ACCT quality assurance process is in place and this reflects the need for quality interactions. All custodial managers will be notified of the need to document clear and specific instructions relating to observations and interactions in the ACCT. This instruction will include the requirement to check for signs of life and the general well being of prisoners on initial unlock."

3. The Governor should ensure that wing managers make clear to officers at the start of each shift, who is responsible for conducting ACCT checks and observations and when they should be done.

   NOMS accepted this recommendation: "All wing managers will be briefed and instructed via a Governor's order on the need to identify individual officers responsible for ACCT checks and at during what periods those observations and interactions should take place."

4. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

   NOMS accepted this recommendation: "As per recommendation three, the instruction regarding checking through cell doors before unlocking will be included in the Governor's order."

5. The Deputy Director of Custody for High Security should ensure that some safer cells are provided at Manchester on standard residential prison wings.

   NOMS accepted this recommendation: "Funding has now been approved to provide safer cells and additional crisis suites on residential wings."

6. The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

   NOMS accepted this recommendation: The Head of Healthcare and the Governor will draft clear guidelines for staff about the circumstances in which resuscitation is not appropriate. This will be reiterated to staff via notice to staff and emphasised through Safer Custody Meetings.

7. The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously and dealt with in line with local and national policies.

   NOMS accepted this recommendation: "The policy on anti-social behaviour / bullying has been reviewed and suitable amendments made. All incidents of bullying are now logged through the safer custody office and the violence reduction officer co-ordinates, tracks and follows up on investigations done by wing managers."

8. The Governor should ensure that where possible staff from Manchester should visit the next of kin in person to break the news of a death unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.

   NOMS accepted this recommendation: The Governor will ensure where possible that staff from Manchester will visit the next of kin. The Governor will consider carefully when it is appropriate for family liaison officers from other prisons due to distance.