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 Risley 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 an investigation into the death of a man, who was found hanging in his cell at HMP Risley in December 2012. He was 35 years old. I offer my condolences to his family and friends.

A clinical reviewer was conducted into the clinical care that the man received at HMP Manchester and at HMP Risley. HMP Risley cooperated fully with the investigation.

The man was convicted of arson in an apparent attempt to kill himself. He was first held at HMP Manchester where he had had periods of depression and attempted to harm himself. He was monitored under suicide and self-harm prevention procedures and treated by mental health staff. When he subsequently moved to Risley, he did not tell the reception staff about his previous attempts to harm himself. He was never regarded as a risk of suicide or self-harm while he was at Risley. In December he was found hanging from a light fitting in his cell. Resuscitation was not attempted as it was evident to the nurse who attended that he had been dead for some time. Paramedics arrived and confirmed his death.

The investigation has found that the monitoring of the man's risk of suicide and self-harm at HMP Manchester was closed inappropriately, limiting the information sent electronically to HMP Risley. Once at Risley, his risk was not properly assessed and all necessary documentation was not reviewed. Similarly, a mental health referral was not given sufficient priority because information about the seriousness of his mental health problems was overlooked. As a result, he was not seen at all by mental health staff during his time at Risley.

In the period leading up to his death, the man had become particularly distressed by not being able to telephone his father. This was due to administrative failures at Risley. The prison did not respond to his efforts to rectify and complain about the situation.

The man was found hanging from light fittings on B wing. In another investigation at Risley, concluded after he died, we identified the ease with which these light fittings could be used as ligature points and recommended that they be replaced. We also identified the apparent unwillingness of staff to go into cells at night during an emergency, which also occurred in his case. These issues remain to be addressed.

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 **October 2013**

CONTENTS

SUMMARY

1. The man was arrested on charges of arson and remanded into custody at HMP Manchester on 20 August 2012. He said that he had set fire to his home in an attempt to kill himself. He was convicted and sentenced to 28 months imprisonment on 5 November 2012 and was made subject to a restraining order to stop him contacting his ex-partner and her children. At Manchester, he was twice monitored under the Prison Service's ACCT procedures to help prevent suicide and self-harm, once for approximately five weeks when he first arrived and again, but just for one day on 17 November, after some items suggesting he intended to harm himself were found in his cell. We consider that this ACCT was closed prematurely before a review was held and there was no post-closure review as Prison Service procedures require.

2. When the man transferred to Risley on 28 November, reception staff were not aware that he had been subject to ACCT monitoring at Manchester because they did not check the records and he did not mention them. He was referred to the mental health team, but he did not respond to two letters inviting him to make an appointment and no one followed this up. His records were not fully considered when he arrived at Risley, so staff were not fully aware of his mental health problems and his risk of harming himself. He was never identified as a risk of suicide and self-harm at Risley.

3. The man repeatedly asked staff at Risley to put his father's telephone number on the list of numbers he was allowed to call. This was never done and was a source of significant frustration to him. This meant that he had been unable to telephone his father since 11 November, when he was in Manchester.

4. In December a member of prison staff found the man hanging by bed sheets attached to the light fitting in his cell. The member of staff who discovered him hanging waited for others to arrive before going into his cell. The nurse who attended assessed that he had been dead for some time and that resuscitation would not be appropriate. His death was confirmed by paramedics who arrived a short time later.

5. We make seven recommendations to HMP Risley, about reception procedures, information used during health screens and first night interviews, entering cells during night state, light fittings on B wing, and emergency procedures.

6. We also make two recommendations to HMP Manchester about ACCT procedures and the need to review prisoners prescribed antidepressant medication.

THE INVESTIGATION PROCESS

7. The Prisons and Probation Ombudsman was informed of the man's death on 15 December 2012. The investigator issued notices to staff and prisoners informing them of the investigation process and asking anyone with any relevant information to contact her. No one responded.

8. The investigator visited Risley on 31 December, and met the Governor, the duty governor and two officers from the safer custody team. She collected copies of the man's prison records and clinical records, visited the wing and the cell where he lived, and spoke to prisoners who knew him, including one of his friends.

9. The investigator returned to Risley on 29 and 31 January and 1 February. She interviewed staff and a prisoner, as well as visiting the prison's reception area. She gave verbal feedback to the deputy governor and subsequently sent written feedback to the Governor about the preliminary findings of the investigation.

10. The investigator liaised with Cheshire CID, who provided various documents, including a letter left by the man which indicated his intention to take his life.

11. The local PCT commissioned a clinical reviewer to review the clinical care the man received in custody.

12. The investigator informed the Coroner for Warrington of the investigation who provided a copy of the post-mortem report. The Coroner has been sent a copy of this report.

13. One of the Ombudsman's family liaison officers contacted the man's sister to explain the purpose and scope of the investigation and to give his family the opportunity to identify any issues they wished the investigation to take into account. The family raised the following matters:

    - They were concerned that he was on an ACCT at Manchester but not at Risley and asked if any checks had been missed.

    - They wondered if he had portrayed himself as being well, so that staff would leave him alone.

    - They were concerned that other deaths at Risley had happened in the early morning and asked if checks were made then. As he was not on an ACCT, the only required checks were roll checks, which were conducted as normal. He was found at one of these checks.

- They asked why he was locked up 22 hours a day. This was because he did not have a job in the prison and was in line with the prison's policy.

- They asked about why his father's number had not been put on his telephone list.

HMP RISLEY

14. HMP Risley is a category C training prison, which holds up to 1085 adult male prisoners. Healthcare services are provided by the Bridgewater Community Healthcare NHS Trust, Warrington Division. There is 24-hour healthcare cover. During the day, there is a doctor in the prison and at night there is one nurse on duty. There is no inpatient facility.

Her Majesty's Inspectorate of Prisons (HMIP)

15. HMIP last inspected Risley in February 2011. Inspectors noted that reception processes and environment had improved since their previous inspection, and that reception officers were helpful and welcoming. Although prisoners were less positive about the overall quality of healthcare than those in similar prisons, the inspection found that health services were satisfactory. ACCT (Assessment, care in custody and teamwork, the Prison Service framework for assisting prisoners at risk of suicide or self-harm) procedures were described as being generally good, and inspectors found some good multi-disciplinary support for prisoners at risk. Inspectors found that primary and secondary mental health services were good. They also found that the general handling of complaints had improved, but inspectors found some poor responses to complaints.

Independent Monitoring Board (IMB)

16. Each prison has an IMB 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 2012 annual report, the IMB were concerned about the use of the segregation unit to house prisoners with mental health problems and commented on the lack of other suitable accommodation. The IMB were satisfied that safer custody incidents were fully and professionally documented.

Previous deaths at Risley

17. Since 2011, we have investigated nine deaths at Risley, including the man's and three subsequent deaths. We have previously made recommendations about assessing the risk of light fittings at Risley, and about the need for staff to go into cells at night in an emergency.

Assessment and Care in Custody and Teamwork (ACCT)

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of 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.

KEY EVENTS

19. The man was remanded to HMP Manchester on 20 August 2012, after setting fire to his house in an attempt to kill himself. This was his first time in custody.

20. During his reception health screen, the man said that he might try to kill himself again. The Nurse Manager noted in his clinical record that he was tearful, had poor eye contact and appeared emotionally flat. Because of his demeanour, she decided that he should be admitted to the healthcare centre as an inpatient and she opened an ACCT document (used to support prisoners at risk of suicide or self-harm). The nurse drew up a clinical care plan which indicated that he should see the psychiatrist at least weekly, should be allocated a safer cell (a cell designed with fewer obvious ligature points than standard cells) and be encouraged to talk about his feelings.

21. On 21 August, the man told the prison psychiatrist that he had experienced relationship problems for some time. He said that he would harm himself if he could but then said that he would not so because he had to live for his nine month-old son. The psychiatrist noted that he was very low in mood and pessimistic about himself and his future. He had a poor appetite and was very thin.

22. On 27 August, another psychiatrist examined the man. He diagnosed moderate depression for which he prescribed sertraline, an anti-depressant. The psychiatrist agreed that he should stay in the healthcare centre in a safer cell with normal observations and be encouraged to participate in activities.

23. A psychiatrist reviewed the man on 5 September. He told the psychiatrist that his appetite had improved, he was associating with other prisoners and his relationship with his partner was improving. He said that he realised how he had been before coming into Manchester and, although he still had low moods, he wanted to move from the inpatient unit to a standard prison wing. He was due at court on 5 November. The psychiatrist noted in the record that a decision would be made whether he was fit to move to an ordinary wing at an ACCT review on 11 September.

24. The ACCT review actually took place on 10 September. The man said that he had put on weight, that he thought the anti-depressants were helping with his mood and that he wanted to move to normal wing accommodation. The Nurse Manager noted that he spoke very positively about the future. He had decided to plead guilty at court and wanted to progress in prison and get a job. After the review, he moved to G wing but remained on the ACCT. A review was arranged for 14 September. A caremap (which sets out goals to be completed before an ACCT is closed) featured objectives to continue with regular

assessments with mental health staff, to continue with medication and for him to seek employment in the prison.

25. On 14 September, the man attended another ACCT review. Initially, he said that he was reasonably settled on the wing but then became tearful and negative and expressed feelings of worthlessness and self-hatred. It was decided that his next appointment with the psychiatrist would be brought forward. Later in the day, staff on D wing contacted a mental health nurse who had attended the ACCT review, as he was talking about suffocating himself with a plastic bag. Staff thought that his change in mood might have been prompted by a letter he had received that morning from his partner. The nurse spoke to a psychiatrist and the Nurse Manager and they agreed that he should return to the healthcare centre. He told the Nurse Manager that he had received a letter from his ex-partner saying that she would not allow him to see their son. He was then moved to a safer cell in the healthcare centre, on intermittent observations. Later that afternoon, he spoke to a nurse and seemed calmer and more settled.

26. Over the next few days, the man was reported to have engaged with staff and improved in mood. On 17 September, he told staff that he was feeling better and wanted to go back to the wing. He said he was aware that he could ask and receive support if he needed it. The ACCT remained open and he moved to K wing that afternoon, where he seemed to settle.

27. On 26 September, it was decided to close the ACCT after a review. The man seemed more positive, was working, and did not have ideas of self-harm or suicide. He continued to take anti-depressants. He said that he preferred his own company but he enjoyed reading and used the library. He also said he had the support of his family. A post-closure ACCT review took place on 3 October to check that he was still feeling okay.

28. The man attended court on 5 November and was sentenced to 28 months imprisonment. He was also made subject to a restraining order which prevented him from contacting his ex-partner and child. He found this difficult to cope with.

29. On 16 November, an officer conducting a routine search found a noose made from a sheet, two improvised bladed weapons and a spool of white cotton in the man's cell. He told him that it was not a noose and that he had tied the sheet as a deterrent to killing himself. He said that he had made the blades to sharpen crayons and that he had accidentally kept the spool of cotton from when he worked in the sewing shop.

30. The officer opened an ACCT because he was concerned about the man's safety. When he was assessed at 2.30pm, on 17 November, the ACCT was closed again because the member of staff conducting

the assessment did not consider that he was likely to harm himself at that time. The same day, he was found guilty of a disciplinary offence of having unauthorised items in his cell and was punished by a stoppage of earnings, suspended for three months. There is no record that a post-closure ACCT review ever took place and the ACCT was not recorded on his electronic prison record.

31. On 28 November, the man was transferred to HMP Risley, which was nearer to his home. Staff in reception explained to the investigator that, when an escort van arrives, the escort staff pass prisoners' documents, including clinical records, risk assessments, previous self-harm history and cell sharing risk assessments (CSRA), to reception staff. Reception staff then book the prisoners in and log and store their property while the prisoners wait in a holding cell with Insiders (prisoners trained to help those who have just arrived, and to provide information about the prison).

32. First night officers then interview new arrivals and a nurse conducts a health screen. A nurse saw the man at 4.25pm. The nurse told the investigator that when he interviewed him he was not aware of his offence or his history of self-harm at Manchester. He did not have access to previous ACCT records, nor did he see his Person Escort Record (PER, which accompanies prisoners when they are moved). The nurse said that he usually had a "quick-glance" copy of a prisoner's clinical record and the prisoner's cell sharing risk assessment, but that he could not remember if he did for him. (A quick glance report is a summary of a prisoner's health record and is usually two pages.) The purpose of the initial health screen is to ensure that the prisoner has the medication he needs, that any immediate health needs are identified, that the prisoner is referred to the doctor or mental health team if required and to assess any risks the prisoner presents to himself or others.

33. The nurse said that the man had told him he was not taking any medication. (He had been prescribed 28 tablets of sertraline, to be taken one per day, on 22 October, which would have ended on 19 November. According to the clinical record, the prescription was not reviewed or repeated at Manchester.) The nurse told the investigator that a 'quick glance' clinical report would only include the medication he was taking at that specific time. He said that he did not look at the full notes and did not have time to do this for every prisoner. (Nine prisoners arrived at Risley that day.)

34. The nurse told the investigator that the man said that he had not harmed himself outside or inside prison, which he took "on trust". He said that he had not seen a copy of his ACCT document or PER and did not see his CSRA. He did not think that he needed to see the prison doctor, as he was calm and settled during the assessment. However, he referred him to the mental health team because he told him that his previous involvement with mental health services at

Manchester had helped him. The nurse made no further enquiries about the reason why he was supported by the mental health team at Manchester.

35. An officer completed the man's first night assessment in reception. He said that when he interviewed him, he did not see the PER or copies of any ACCT documents and did not know about his previous attempts to harm himself. The officer said that he seemed happy to be at Risley and did not give him any cause for concern. He said that he was aware that his CSRA mentioned that he had been convicted of arson, which would normally put him at a high risk of cell sharing, but he did not know that the motivation was to kill himself and nor did he know he was subject to a restraining order.

36. The officer issued the man with £2 phone credit, which is the routine for all new arrivals. The credit can be used to call any telephone number and expires after 24 hours with any remaining credit added to the prisoner's personal phone account which transfers from the previous prison. When the officer checked the computer records later that night, he realised that there was a restraining order and he should not be allowed to contact his ex-partner. He then spoke to him and removed the phone credit before he had used it. He said that he did not seem upset about this.

37. As part of the induction process at Risley, a member of chaplaincy sees all new prisoners. The chaplain who was on duty that day said that he speaks to new prisoners when they arrive at their cell and completes a form with their personal details and next of kin. He also asks them about previous self-harm or suicide attempts and whether any relatives had died in the previous year. He said that before he sees new arrivals, he checks records to see if anyone had previously been identified as at risk of self-harm. He noticed that the man had been on an ACCT at Manchester. He spoke to him for about 20 minutes in his cell. The man told him that he had been on an ACCT at Manchester. The chaplain asked him what his coping strategies were and he said that he wanted to see mental health staff but that he was currently okay. The chaplain said that he did not have any particular concerns about him and did not consider him to be at risk of harming himself at that time.

38. The next day, 29 November, an officer introduced himself to the man as his offender supervisor. The officer recorded that he had told him that he had initially struggled to cope in prison and had been on an ACCT at Manchester. However, he said that he was 'in a better place now'. The same day the chaplain spoke to him again and noted that he had not raised any issues. On 3 December, an officer spoke to him about skills and work opportunities in prison. He did not record that he mentioned having any problems.

39. On 4 December, the mental health team discussed the man's referral, using only the information from the nurse's health screen. An officer who was at the meeting told the investigator that they were not aware that he had previously harmed himself as this had not been noted on the health screen. She told the investigator that the meeting referred to his medical record and computerised prison record (known as P-NOMIS). She said that they were aware that he had been on an ACCT at Manchester, but they did not have the full ACCT document and they understood that he had been periodically depressed because his relationship with his partner had broken down.

40. The team agreed that the man would be referred to Mental Health Matters, the team within the prison that deals with general mental health issues, such as depression and helps prisoners develop coping strategies. An invitation letter was sent to him that day, asking if wanted to make an appointment. He did not respond to the letter, so the team sent another letter on 12 December. During this time, he did not have any contact with mental health staff or a prison doctor.

41. When a prisoner transfers to Risley, the sending prison passes on his list of approved telephone numbers. Once these have been checked at Risley, they are added to the prisoner's account and can be called, as long as the prisoner has credit. After his PIN numbers were agreed, the man called his mother on 29 November. However, his father's number had not been included on the list.

42. On 3 December, the man applied to have his father's telephone number put on his account. He put in two more written applications, on 10 and 11 December, to ask for his father's number to be added. On 12 December, he made a formal complaint about this and said he had not been able to speak to his father since 11 November. He got no response to any of these applications or the complaint.

43. A prisoner became friends with the man at Risley. They were initially on D wing together and then both moved to B wing where the prisoner's cell was on the opposite side of the landing to his. The prisoner said that they often talked and that he found him very supportive. He said that the man had been trying to telephone his parents on the night of 13 December. (He could not get through to his mother and his father's number had still not been added to his account.) The man had told him that he was expecting a parcel for Christmas with photographs of his son.

44. One morning a few days later, an Officer Support Grade (OSG) was carrying out a roll check on B wing to ensure that all prisoners were accounted for and in their cells before he finished his night shift. (The well-being of prisoners is not checked at roll checks or other times during the night unless they are required to be monitored under ACCT procedures.) When he opened the observation hatch of the man's cell he said he saw him suspended by a ligature around his neck and tied

to the light fitting. He immediately radioed a code black (a code used at Risley to call for assistance in a life threatening emergency). He stayed at the cell door until a Senior Officer (SO) came to help, which, according to the OSG, was within a few minutes. The SO then unlocked the door and they both went in. The OSG supported the body while the SO used his anti-ligature knife to cut the sheets by which he was suspended. They then placed him on the floor of the cell and the SO went to unlock the gate for the nurse to get onto the wing.

45. The OSG said that another SO and a nurse arrived at the cell within a few minutes and he then continued to check the other cells. The nurse said that when she heard the code black emergency call she was in the healthcare centre. She grabbed the emergency equipment bag and went to B wing. At night nurses do not have keys to get onto the wings and she said that she waited at the gate for approximately five minutes before a SO let her onto the wing.

46. When the nurse arrived at the man's cell, she said he was lying on the floor and had a deep indentation mark around his neck. She could not find a jugular or a peripheral pulse. She noticed mottling on his skin and that he was cold to the touch. She had previous hospital training in assessing whether someone had died and decided that he had been dead for approximately three or four hours. The staff therefore did not start cardiopulmonary resuscitation or other emergency treatment. The nurse called for an ambulance and paramedics arrived about ten minutes later. They agreed with her assessment and pronounced him dead.

47. After the man's death, prisoners on B wing were offered support. Prisoners on ACCTs were reviewed in case they had been adversely affected by his death. The Governor held a hot debrief to offer support to staff.

48. A card addressed to the man's son and a letter to his father was found in his cell. In the letter, he asked his father to telephone the prison to find out why they had not yet allowed his number to be added to his phone list. At the end of the letter he wrote that he was now at his "wits end". Below this he wrote:

> "You know what fuck it all I wanted was number on cannot be arsed so I end my life".

49. The prison family liaison officer, the co-ordinating chaplain, was informed of the man's death at 7.15am on 15 December. He went to the prison to be briefed about what had happened and then he and a SO went to the man's mother's home. They arrived at 9.30am and informed her and the man's sister of his death. His family agreed to inform his ex-partner. The SO arranged for the family to visit the prison and supported the family through the funeral process. The prison contributed towards funeral costs, in line with national guidance, and

returned his property to his family. At his family's request, the chaplain presided over a service when the ashes were buried.

ISSUES

Clinical care at Manchester

50. While at Manchester, the man spent time in the inpatient unit being cared for by healthcare staff. The clinical reviewer considers that he was cared for appropriately at Manchester. However, when his last prescription for his anti-depressants ended, it was not reviewed or repeated. It is not clear what impact this had on his mood, but he was not on medication when he arrived at Risley and was not given any further medication there. Without a review being held when a course of anti-depressants ends, there is an increased risk that some prisoners will be less able to cope and will therefore present a greater risk of suicide or self-harm. We make the following recommendation:

The Head of Healthcare at Manchester should ensure that prisoners are reviewed when prescriptions for anti-depressants expire.

Clinical care at Risley

51. When the man arrived at Risley, a nurse carried out an initial health screen. The nurse said that he did not know that he had been on an ACCT at Manchester and was not aware of his offence. The nurse looked only at a summary of his clinical records, and told the investigator that there was not enough time to review all documents at an initial health screen.

52. The nurse referred the man to the mental health team but he did not respond to two letters inviting him to make an appointment. The investigator was told that if a prisoner did not respond to two invitations they would be discharged from the team. He had not responded before his death.

53. The clinical reviewer comments in his review that the fact that the man had mental health problems was recognised but that their nature and extent were not fully appreciated. We agree with him that the nurse who conducts the health screen should not have relied solely on what he told them at reception and there should have been a back-up procedure, particularly as he had been on a long-term ACCT when he was at Manchester. Prison Service Instruction (PSI) 74/2011 states that “all medical records transferred with the prisoner must be examined as part of the [medical] assessment”. It is clear that staff at Risley do not routinely do this. We make the following recommendation:

The Governor and Head of Healthcare at Risley should ensure that all relevant records are fully reviewed before or during a health screen assessments.

54. The clinical reviewer considered that if, as the nurse thought, there were too many prisoners in reception to obtain a full history for each, this meant that there needed to be an effective back-up system in place. He describes the liaison between Manchester and Risley as "not optimal". Prison Service Order (PSO) 3050, on continuity of healthcare for prisoners notes that receiving a new prisoner following transfer, is equivalent to registering with a new NHS primary care practice and that, during the consultation, the healthcare team should make "proper enquiries and undertake such examinations as appear to be appropriate in all the circumstances". PSI 74/2011 says that assessments can wait till the next day if prisoners are transferring from another prison so that they can do a "detailed medical assessment". The man did not get a detailed assessment or have a secondary health screen, which might have provided a further opportunity for staff to assess his mental health. We make the following recommendation:

The Head of Healthcare at Risley should ensure prisoners are offered a secondary health screen when there is not time to carry out a detailed health assessment on the day of arrival.

Assessment of risk

55. The investigator spent time in the reception area at Risley and noted that documents for arriving prisoners were put into different pigeonholes in the reception area. She checked what information nurses obtained before they interviewed a new prisoner. The nurse took an envelope marked confidential from one of the pigeonholes and worked in a room with a computer where she could access the full medical notes of any prisoner. The investigator noted that the first night officer seemed only to pick up a cell sharing risk assessment before seeing a prisoner. The prisoner's core records and any ACCT documents were put separately into a different pigeonhole.

56. The first night officer said that he based his assessment of the man on what he told him. He did not check the PER or his previous ACCT document and he did not check his sentencing information until later that night. An officer said that reception was staffed to receive six prisoners per day and that he was also expected to supervise movements from education and workshops which took him away from reception duties for some time. The officer said this limited the time he had to spend checking information about new prisoners, although he did not say that he had been taken away from his first night duties on the day the man arrived. In this case, the officer was not aware of his history and possible elevated risk of self-harm.

57. Prison Service Instruction (PSI) 64/2011, chapter 3, contains information relating to times when risks of self-harm might be increased. The PSI notes that transfers between prisons, previous ACCTs and relationship problems are potential triggers for increased risk of self-harm and should be taken into account when assessing this

risk. It does not seem that these risk factors were considered when the man was assessed at Risley. We make the following recommendation:

The Governor of Risley should ensure that first night officers review all relevant documentation before interviewing prisoners to assess their risk of suicide and self-harm.

ACCT

58. The man was subject to suicide and self-harm procedures (ACCT) on two occasions at Manchester. The first ACCT was opened on 20 August, and closed on 26 September when he was considered to be no longer at risk. The actions on the caremap were completed. The other ACCT was opened on 16 November, after a noose and sharp implements were found in his cell. The first ACCT document was satisfactorily maintained, reviewed appropriately and sent with his other records to Risley. However, the second ACCT was only open for a day, was closed at the assessment stage and no caremap was completed. There was no ACCT review before it was closed and there was no post-closure review.

59. The man transferred to Risley on 28 November, 11 days after the last ACCT was closed. The second ACCT was not sent to Risley, and the ACCT was not recorded on his electronic prison records. This meant that staff at Risley were not aware of his most recent ACCT.

60. We believe that this second ACCT was not closed in accordance with Prison Service Instruction 64/2011. Although there is no direct prohibition on assessors closing ACCTs, the section on assessments has a mandatory action that the assessor should, where possible, attend the first case review. In ACCT guidance, a flowchart describes the ACCT process. In the flowchart, the first mention of closure comes after the first case review, which would mean that the ACCT cannot be closed at the assessment stage, as seems to have happened in this case. It appears that staff at Manchester considered that the second ACCT was effectively not opened. It was therefore not noted on his electronic record and not sent to Risley. We make the following recommendation:

The Governor of Manchester should ensure that ACCTs are not closed before a full case review is held.

Contact with family

61. When the man arrived at Risley he was given £2 phone credit which he could use to call any number. He was subject to a restraining order preventing him from contacting his ex-partner and his child. As reception staff did not consider the sentencing information at the first night interview, they were unaware of the order and gave him £2 telephone credit. This was taken off him later that night before he

could use it. Implementation of our earlier recommendation that first night officers review all relevant documentation should prevent such a situation recurring.

62. When the man transferred from Manchester his father's telephone number should have remained on his list of approved numbers but this did not happen. He put in a number of applications to have his father's number reinstated on his phone list. He also made a formal written complaint. He received no reply and was not informed why there was a delay. His father also spoke to staff at the prison on a number of occasions to confirm his numbers. It is clear from the letter that he left that he was very upset about not being able to speak to his father and he specifically related this to his decision to take his life.

63. The Governor commissioned an investigation into why there was such a delay in dealing with the man's request to have his father's number put on his approved telephone list. The investigation indicated that there had been a new member of staff in the phone records office and that, while he was learning the new role, a backlog had developed. The Governor arranged for staff to reduce the backlog through overtime, but this was evidently a management failure at the time. This is a tragic reminder of how important it is for prisoners to be helped to maintain their family ties in prison, particularly prisoners in distress. We make the following recommendation:

The Governor of Risley should ensure that, unless there are public protection issues, newly arrived prisoners should have their family contact telephone numbers activated within a week of transfer.

Light fittings at Risley

64. We investigated another death on B wing at Risley in 2011 in which the light fitting had been used as a ligature point and recommended that the wing light fittings should be assessed to identify if any modifications could be made to make them safer. We have been told that the prison's works' manager is currently waiting for costings on replacing the light fittings.

65. When the investigator spoke to the Governor about the light fittings and the previous recommendation, he did not consider that B wing was fit for purpose. The Governor said he had discussed closing it down with NOMS but, at that stage there was no indication that B wing would be closed. In these circumstances, we make the following recommendation:

The Governor of Risley should ensure that lights in cells on B wing are replaced with safer fittings as soon as possible.

Emergency response

66. When the OSG checked the man's cell and saw him hanging, he did not use his emergency key to enter the cell immediately. He radioed for assistance and waited several minutes for a SO to arrive before they entered the cell. The usual procedure is for three officers to be present if a cell is opened at night but in an emergency the night operating procedure explicitly allows for staff to unlock a cell on their own "where there is or appears to be, immediate danger to life". This was reinforced by Chief Executive of the National Offender Management Service, who wrote to prison governors in January 2010. He reminded prison staff that:

> "Staff have a duty of care to prisoners and to themselves and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger".

67. The OSG said that he would never open a cell door without another member of staff being present. While we accept that ultimately the decision has to be for the individual to make, based on a dynamic risk assessment at the time, it is a serious concern that a permanent member of night staff should consider that there are no circumstances in which he would enter a cell alone, even in life-threatening situations.

68. We made a previous recommendation to Risley about this in January 2013. While we understand that there are risks to staff if they open a cell on their own during the night when fewer staff are available, we consider that preservation of life should be paramount. If there is no reason to suspect that a prisoner might be violent or prone to escape and the prisoner is clearly in a life-threatening situation, we would expect an officer to use his or her emergency key to preserve that life. That is the purpose for which they are issued. We repeat our previous recommendation:

The Governor of Risley should ensure that all staff are aware that, subject to a personal risk assessment, and providing there is no danger to themselves or others, staff should enter a cell on their own at night in order to preserve life.

69. A nurse told the investigator that, during night state, healthcare do not have keys to get onto the prison wings and have to wait for a senior officer to meet and escort them. She waited approximately five minutes. While it is clear that this would not have changed the outcome for the man, in other emergency situations this could mean the difference between life and death. The investigator discussed this with the Deputy Governor, who said this could be reviewed. We consider the prison should do everything it can, as the Chief Executive of NOMS said, to ensure that the preservation of life is placed over security concerns. The current arrangements mean there is an

inherent delay in healthcare staff reaching a prisoner in an emergency at night.

The Governor of Risley should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.

RECOMMENDATIONS

1. The Head of Healthcare at Manchester should ensure that prisoners are reviewed when prescriptions for anti-depressants expire.

2. The Governor and Head of Healthcare at Risley should ensure that all relevant records are fully reviewed before or during a health screen assessments.

3. The Head of Healthcare at Risley should ensure prisoners are offered a secondary health screen when there is not time to carry out a detailed health assessment on the day of arrival.

4. The Governor of Risley should ensure that first night officers review all relevant documentation before interviewing prisoners to assess their risk of suicide and self-harm.

5. The Governor of Manchester should ensure that ACCTs are not closed before a full case review is held.

6. The Governor of Risley should ensure that, unless there are public protection issues, newly arrived prisoners should have their family contact telephone numbers activated within a week of transfer.

7. The Governor of Risley should ensure that lights in cells on B wing are replaced with safer fittings as soon as possible.

8. The Governor of Risley should ensure that all staff are aware that, subject to a personal risk assessment, and providing there is no danger to themselves or others, staff should enter a cell on their own at night in order to preserve life.

9. The Governor of Risley should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.

ACTION PLAN: The Man – HMP Risley and HMP Manchester

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	***HMP Manchester*** The Head of Healthcare at Manchester should ensure that prisoners are reviewed when prescriptions for anti-depressants expire.	Accepted	The medication that was prescribed was not 'in possession' so the man would have collected it daily from the nurses at the treatment room. If a prescription expires a nurse would ask for this to be re-written. Unfortunately we are no in possession of the prescription to identify if this was completed. All clinicians will be notified of the importance to review expired prescriptions.	30th Sept 2013	
2	The Governor and Head of Healthcare at Risley should ensure that all relevant records are fully reviewed before or during a health screen assessments.	Accepted	All nursing staff working in the reception area is expected to review the patient record prior to seeing the patient. If records are particularly lengthy or complex it is appropriate to take the main and recent points of note and then review the record in more detail either later in the day or the following day. If there are an unusually high number of patients being screened at reception it is appropriate to scan the record and then review it in more detail once reception clinic has ended, adding notes and re-	12th July 2013	To be reviewed January 2014

			requesting to see the patient if necessary. All staff has been reminded of the importance of reviewing notes at the time of reception and documenting their findings through daily staff meetings and will receive a personal letter to this effect.		
3	The Head of Healthcare at Risley should ensure prisoners are offered a secondary health screen when there is not time to carry out a detailed health assessment on the day of arrival.	Accepted	All offenders arriving at HMP Risley have been resident in a previous establishment where a first health screen is conducted. On arrival at HMP Risley all offenders are offered a transfer health screen which seeks to reassess the information already provided, add any new information and ensure continuity of care. Following reception screening patients are referred on to various clinics dependent on need for further assessment. Where there is insufficient time to carry out the full transfer screen for whatever reason immediate needs are met and the patient should be invited to return to Healthcare the following day to complete the screen in more detail. Included in the letter to staff noted in point 2 is a reminder of the above.	12th July 2013	To be reviewed January 2014

4	The Governor of Risley should ensure that first night officers review all relevant documentation before interviewing prisoners to assess their risk of suicide and self-harm.	Accepted	First night officers have been informed of the need for them to review all relevant documentation (PER form, CSRA form, any ACCT documents etc) before interviewing any prisoner to assess their risk of suicide and self harm. The Custodial manger and Supervising officers who have responsibility for first night procedures have been reminded of the correct procedures to use. A Notice to Staff will be published to all staff reminding them of PER forms and the importance of completing / reviewing fully.	31st August 2013	To be reviewed January 2014
5	***HMP Manchester*** The Governor of Manchester should ensure that ACCTs are not closed before a full case review is held.	Accepted	The custodial managers now manage all elements of the ACCT review process. They will be notified of the importance of holding a full review prior to any ACCT closure, even at an early stage.	30th Aug 2013	
6	The Governor of Risley should ensure that, unless there are public protection issues, newly arrived prisoners should have their family contact telephone numbers activated within a week of transfer.	Accepted	The majority of prisoners transfer in with their numbers still active on the PIN system however some prisons de-activate numbers. The day after reception (Monday to Friday) the PIN Phone clerk sends a list of the numbers to the prisoner asking if they are the correct and which ones they want	31st July 2013	To be reviewed January 2014

			activated, this is then returned to the PIN clerk to activate any missed numbers. This should all happen within the first few days after transfer. All applications are date stamped when they are received to ensure there are no undue delays. Governance procedures are in place to monitor this.		
7	The Governor of Risley should ensure that lights in cells on B wing are replaced with safer fittings as soon as possible.	Accepted	Head of Residential and the Head of Works department have surveyed the lights and a bid is being submitted for the full replacement of light fittings to a safer cell standard. As an interim solution 'anti-pick' mastic is being applied to all the light fittings on B Wing – this will reduce the opportunity for ligature points around the light fitting. This has been identified as a priority and will be commence week commencing 8th July 2013.	31st October 2013	To be reviewed January 2014
8	The Governor of Risley should ensure that all staff are aware that, subject to a personal risk assessment, and providing there is no danger to themselves or others, staff should enter a cell on their own at night	Accepted	This has been reiterated to all staff and specifically to staff who regularly conduct night duties. Half of the nights staff have been trained with regards to this, the other half are due to be trained. A letter from Michael Spur has been	30th September 2013	To be reviewed January 2014

	in order to preserve life.		forwarded to all staff reminding them of the actions required. All night staff have been given copies of the LSS instruction 2.77 that states that Staff have a duty of care to prisoners and to themselves and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger.		
9	The Governor of Risley should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.	Accepted	A review is being undertaken of the keys that are issued to healthcare staff at night. Healthcare staff will be issued with an additional key that will ease movement and reduce unnecessary delays during night state.	30th September 2013	To be reviewed January 2014