PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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

Our Vision

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

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Hewell in November 2013. He was 33 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the clinical care and treatment the man received at Hewell. The prison cooperated fully with this investigation.

The man had been released from a prison sentence at Hewell on 19 September, but recalled the next day, after being charged with a new offence of burglary. He was immediately admitted to the healthcare unit to manage his medication and because he had a complex medical history, including a diagnosis of Munchausen's syndrome and previous self-harm. He complained of constant pain from a previous injury, but no obvious clinical cause could be found. On 3 October, he began to be managed under suicide and self-harm prevention procedures, after a doctor reduced the level of pain relief medication. This continued for the rest of his time at the prison.

On 1 November, the man was discharged from the healthcare unit, but staff continued to monitor him because of his assessed risk of suicide and self-harm. Several days later he was found hanging in his cell. Staff began cardiopulmonary resuscitation and called for an emergency ambulance. When paramedics arrived, they confirmed that he had died.

Although more might have been done to help alleviate his pain, the clinical reviewer was satisfied that the man's healthcare needs were generally well met at the prison. He was monitored closely while he was an inpatient in the healthcare unit, with frequent multi-disciplinary case reviews, but suicide and self-harm prevention procedures were not so good when he moved to a residential houseblock. On the houseblock, there were different case managers for each review, no attendance by healthcare staff at reviews and a lack of clarity about the level of assessed risk. However, I recognise that it would have been difficult to predict his actions. It is apparent that he was a very complex man to manage and, despite the identified procedural deficiencies, I consider that he received a reasonable standard of care at the prison.

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 **July 2014**

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SUMMARY

1. The man was released from HMP Hewell on 19 September 2013. He was recalled to prison the next day, after being charged with burglary. He was returned to Hewell. He had a complex medical history and complained of constant pain. When he arrived he was admitted to the healthcare unit as an inpatient so that his medication could be monitored.

2. On 3 October, a doctor reduced the level of the man's pain-relief medication. The doctor began suicide and self-harm prevention procedures (known as ACCT) as he was concerned that he might harm himself in response to the changes in his medication. He was managed under ACCT procedures until he died. On 15 October, while living in the inpatient unit, he harmed himself by cutting his arm. Plans began to be made to move him to a standard houseblock. He was not happy about this and said he would kill himself if he was moved. On 1 November, he was discharged from the healthcare unit to a standard residential houseblock.

3. The man continued to be monitored as at risk of suicide and self-harm when he moved to the houseblock. On 4 November, an ACCT review, which was not attended by any healthcare staff, assessed his risk of suicide and self-harm as low and reduced the level of monitoring to two observations an hour from four. At an ACCT review on 13 November, his risk was assessed as raised yet the level of observations was reduced to one an hour.

4. Just after midday on the day of the incident, the man told an officer that he had just heard that a member of his family had died. (He told the prisoner in the next cell to him that it was his father who had died.) After his death it was established that there had been no recent family bereavement, but the officer did not know this at the time. He did not consider whether this news would immediately affect his level of risk, or discuss this with his managers. He said he would speak to him later and recorded what he had told him in the ACCT document. When he went to speak to him at 2.12pm he found him hanging in his cell. He radioed an emergency code and control room staff called an ambulance immediately. Other officers arrived very quickly and began cardiopulmonary resuscitation. Paramedics arrived, but after further resuscitation attempts they confirmed that he had died.

5. We found that overall the care that the man received at Hewell was equivalent to that he could have expected in the community. The emergency response when he was found hanging in his cell was swift and appropriate. However, some aspects of the suicide and self-harm monitoring procedures were not as effective as they could have been, especially after he moved from the healthcare centre to a residential houseblock. There was no continuity of case management; his level of risk was not assessed or entered appropriately in the documents and, after the move, there was only limited input from the healthcare team, although his identified risks and issues were related to his clinical care. A previous ACCT post-closure review was not completed as it should have been and he did not receive either a physiotherapy appointment or a special mattress which had been ordered for him, both of which might have helped him cope with his pain.

THE INVESTIGATION PROCESS

6. The investigator visited HMP Hewell on 22 November 2013 and obtained relevant records about the man. Notices were issued to staff and prisoners inviting anyone with information to contact him. He met the Governor and interviewed nine members of staff and two prisoners on 10 and 11 December. Written feedback about the preliminary findings of the investigation was sent to the Governor on 12 December. Another investigator interviewed the man's cellmate who had moved to HMP Swaleside

7. NHS England appointed a clinical reviewer to assess the man's clinical care at the prison.

8. The investigator informed Her Majesty's Coroner for Worcestershire of the investigation, who provided a copy of the post-mortem report.

9. One of our family liaison officers contacted the man's family to inform them about the investigation and to invite them to identify issues which they wanted the investigation to consider. The family did not have any specific issues for the investigation to take into account. They received a copy of the draft report and had nothing they wished to add.

HMP HEWELL

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

HM Inspectorate of Prisons

11. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Hewell in November 2012. Inspectors identified a number of significant concerns about staff morale, poor practice and cleanliness. They noted that too many prisoners in the local prison shared cells designed for one.

12. Inspectors found that not all PPO recommendations related to previous deaths at the prison had been implemented. Some personal officers had a reasonable knowledge of prisoners, but the frequency of staff entries in prisoners' case notes varied and reflected a lack of engagement.

13. Inspectors found that the range of health services to be generally good and inpatients in the healthcare unit were positive about their treatment. Mental health and pharmacy services were assessed as satisfactory, but some issues about the security of medicines needed to be addressed.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. The most recently published IMB annual report for 2012 noted that the number of incidents of self-harm had decreased slightly. The IMB considered that safer custody meetings were thorough and a new safer custody policy provided clear guidance for staff.

Previous deaths at Hewell

15. There were five deaths at Hewell during 2013, including the man's. In one of these investigations we were concerned about the lack of personal officer input into the care of the prisoner. Although he had not been allocated a nominated personal officer, his ACCT document indicates frequent staff interaction.

KEY EVENTS

16. The man was born in September 1980. He had a titanium plate in his neck as a result of an injury which resulted in several vertebrae being removed in 2009, while he was a prisoner at HMP Wayland. He had complained of pain before this injury, and continued to do so throughout his time in prison, and was prescribed a range of pain killers. He also suffered from an overactive thyroid. He had been diagnosed with a personality disorder and Munchausen's syndrome (sufferers of which intentionally produce or pretend to have physical or psychological symptoms of illness). He also had a history of self-harm. He had served several previous custodial sentences, and had harmed himself while in prison.

17. On 3 September 2013, the man arrived at HMP Hewell after his release on licence from a previous sentence was revoked when he breached the terms of his licence. A mental health nurse noted that he had just been released from hospital after deliberately ingesting a spoon, which was removed following an operation. He reported being in pain, but said that he did not have any thoughts of self-harm. She wrote in his medical record that she would open an ACCT if one had not already been opened (it had not been). He was admitted to the inpatient unit so that his pain and mobility as a result of his injury could be monitored.

18. Later that evening, a nurse went to book the man's medication into the controlled drug register, but found that a large number of oxycodone tablets he had been prescribed and should still have had were missing (oxycodone is an opioid pain relief for moderate to severe pain). Nurses assumed that he had already taken the medication. He was tearful and requested further pain relief but the doctor decided for safety reasons not to give him any further oxycodone. Just before 10.00pm, a nurse began ACCT procedures as he was distressed at not being given pain relief and he had a recent history of self-harm. For his safety, officers removed all the belongings from his cell, which he said was cruel. The nurse set the level of observations at five an hour.

19. The copy of the ACCT document that we were given did not include the assessment, care map or first case review which might have explained these decisions. The man was monitored as planned, although we note that one officer made a single entry to cover five observations on three separate occasions on the morning of 4 September.

20. At 2.35pm on 4 September, the man shouted for help and staff found him lying on the floor of his cell. He said that he had injured his neck and was in pain. A nurse decided not to move him because of the nature of the injury and asked a doctor to assess him. He refused to take tramadol (a pain killer) when it was offered. The doctor reviewed his medical records and agreed he could be given oxycodone. He sat up once a nurse showed him the oxycodone.

21. ACCT reviews were held on 5 and 9 September. The man's level of risk was assessed as low both times and he said that he had no thoughts of suicide or self-harm. A nurse closed the ACCT on 9 September and set a post-closure review date of 16 September.

22. On 13 September, a doctor examined the man, who said that he had no feeling in his thigh. The doctor asked him to walk to the door and he fell to the floor, then got up and walked to the door. He had been seen walking without problems earlier that day, but was unable to explain this.

23. The ACCT post-closure review, which had been scheduled for 16 September had not taken place by 19 September, when the man was again released on licence. He was arrested for burglary the same day. While he was in police custody, a mental health nurse noted that he had a personality disorder, but did not have any thoughts of self-harm. Nevertheless, a police doctor decided that he should be constantly monitored while he was in police custody. On 20 September, at Magistrates' Court, he was remanded to prison until 30 December, when he was due to appear at Crown Court. He was taken back to Hewell.

24. When he arrived at Hewell on 20 September, the man returned to the healthcare unit as an inpatient to ensure that his medications were appropriately managed. (He had been located in the inpatient unit for his previous stay between 3 and 19 September.) He was prescribed oxycodone, gabapentin (moderate to severe pain relief), oxycontin (narcotic pain relief for moderate to severe pain), thyroxine (for underactive thyroid) and omeprazole (for gastric conditions). Healthcare staff were concerned that he had already taken more than his prescribed dose of oxycodone that day. The next day, he told a doctor that he had not taken his medication for a couple of days and was in pain.

25. On 26 September, the man discussed his pain with a nurse and told her that he did not think that his needs were being met. He said that he was coping with his pain, but being in prison and worrying about his family relationships was causing him stress that he felt unable to cope with. She advised him to remain positive, write his feelings down and to think about how his actions affected him.

26. The next day, 27 September, a nurse noted that the man had been rather quiet and thought that this might have been because it was his birthday. She saw him again the next day and noted that he had been subdued and had chosen to remain in his cell. On 1 October, he asked a nurse to get him some cigarette papers from another prisoner, but she refused. He then asked for some gabapentin. When she told him that he had already received his dose of gabapentin, he became verbally hostile and also threw items around his cell.

27. On 2 October, an officer held the ACCT post-closure review which should have been conducted on 16 September, before the man was released from prison. He said that his previous problems had been about medication which had now been resolved. The officer decided that the ACCT should remain closed.

28. On 3 October, a doctor reviewed the man's medical record after he had complained of paralysis in his limbs but had then been seen kicking his cell door with some force. The doctor noted that he had an extensive medical history and had a confirmed psychiatric diagnosis of Munchausen's syndrome, personality disorder and a history of self-harm. He had been referred to hospital many times, and one in particular in August 2013 for CT and MRI

scans. The discharge summary from the hospital, which had been sent to the prison, said that there was no medical or clinical cause for his pain.

29. A doctor consulted a pharmacist about the type and level of medication that the man should be prescribed. The pharmacist advised that the level of oxycodone should be reduced from 100mg to 80mg. The doctor told him that his dose of oxycodone was to be reduced, but he would still be able to request one sixth of his daily dose on demand, for breakthrough pain relief. He became upset and, because of his risk of self-harm, the doctor opened an ACCT document at 4.00pm.

30. A nurse completed an immediate action plan and set observations at every 30 minutes. She recorded that the man was aware that he could speak to the Samaritans or a Listener (a prisoner trained by the Samaritans). He would not engage with the doctor or the nurse and refused to sign the ACCT document.

31. On 4 October, at 10.00am, an officer noted that the man refused to cooperate with an interview for an ACCT assessment and recommended that the level of observations should remain unchanged at twice an hour. Later that morning, he refused to participate in the first case review, chaired by the mental health team manager. She recorded that his level of risk of suicide and self-harm was raised and that he should continue to be observed twice an hour.

32. For the rest of the day, the man refused to eat unless his level of medication was raised again. A nurse recorded that she had told him that his medication would have to be withheld if he refused to eat as it was unsafe for him to have it on an empty stomach. He then decided to eat.

33. On 7 October, a nurse chaired an ACCT review which an officer attended. The man said that he was reluctant to engage in the review as he did not consider that the ACCT should have been opened and he had no thoughts of suicide or self-harm. The review concluded that he was at low risk of suicide and self-harm and reduced the level of observation to once an hour. The nurse completed an ACCT caremap which identified his medication as his only issue.

34. On 14 October, the man was reported to be verbally abusive towards nurses when he went to collect his medication that evening. He alleged that the nurses had been manipulating the doctors into changing his medication. A nurse warned him about his behaviour.

35. That night (14/15 October), the man asked to see a Listener. He complained to staff about his medication and a nurse raised the level of observations to two an hour until an ACCT review later that afternoon. At 2.51pm, a nurse noted in his medical record that there was no clinical reason for him to remain as an inpatient. The nurse chaired the ACCT review, which also noted that he did not need to remain as an inpatient. He said that he was not happy with his treatment. The nurse reduced the level of observations to hourly and assessed his risk as low. The nurse added an action to the caremap, for the doctor to review his medication.

36. At 4.00pm on 15 October, the man harmed himself by cutting his left arm. A nurse cleaned and dressed the wound but he would not allow the nurse to use steri strips (sterilised adhesive stitches).

37. The mental health team manager held a further ACCT review at 4.24pm which an officer and a healthcare assistant attended. The man said that he was distressed as he was in a lot of pain and had harmed himself because of his treatment and the reduction in his medication. The manager assessed that he was at raised risk of self-harm and increased his level of observation to twice an hour. She noted that he would remain as an inpatient until there was a further review.

38. At 10.20pm, the man opened up the wound on his arm with an implement made from a cigarette lighter and a Supervisory Officer (SO) held another review which two officers and a nurse attended. He said that he had harmed himself out of frustration. He handed in his lighter and staff searched his cell and removed other items that they thought he might use to harm himself. The level of observation remained at twice an hour and a further review was set for the next day.

39. On 16 October, at 11.45am, a prison doctor saw the man, who said that the he was in even more pain since his medication had been reduced. He said that it would help if he had his own foam mattress. The doctor noted that he did not keep good eye contact and would not give him a straightforward answer when he asked him if he would agree to see a pain specialist. He kept repeating that healthcare staff were leaving him in pain. The doctor recorded a plan which included an aim to discharge him from the healthcare unit. His dose of oxycodone was to be reduced and he was to be referred to a physiotherapist to see if there were any complementary therapies that would help him and he would be prescribed zopiclone for three nights to help him sleep.

40. At approximately 12.30pm, a nurse recorded in the ongoing record that the man had harmed himself and threatened to end his life. The nurse held an immediate ACCT review, attended by a healthcare assistant and three prison officers. He said he was still unhappy about his treatment and would not engage with the rest of the review. He continued to harm himself by opening his wounds. The staff searched his cell again but found no concealed weapons or implements. The nurse added an action to the careplan, to ensure that a doctor reviewed him.

41. Later, the man spoke at length to an officer, who was responsible for constantly supervising him that evening. He told the officer that he was unhappy that his medication had been changed, and that he needed an orthopaedic mattress. He handed the officer a small metal object that he had used to cut himself. The officer noted that he fought off sleep for much of the night, but spent most of the next morning asleep.

42. On 17 October, the mental health team manager chaired an ACCT review which an officer attended. At the review, he said that he did not want to die, but had harmed himself because he was frustrated about the change in his medication. The review considered that he remained at a raised risk of suicide and self-harm but reduced the level of observation from constant to five times an hour.

43. On 18 October, the duty governor chaired an ACCT review, which an officer attended. No one from the healthcare team was present. The man said he

was still concerned about his medication and his level of pain, but said he had no thoughts of self-harm. He was assessed as still at a raised risk of suicide and self-harm and the level of observation continued at five times an hour.

44. On 19 October, a custodial manager chaired an ACCT review which two officers and a nurse also attended. The man said his views had not changed since the last review, he had no thoughts of self harm and that the ACCT served no purpose. The review maintained his level of risk of suicide and self-harm at raised, but reduced the level of observations from five to four an hour. He continued to complain, on this and many other occasions throughout October, that he did not receive his medication when he needed it.

45. On 21 October, at 11.30am, the mental health team manager and an officer held an ACCT review. The man said that he did not want to harm himself and did not care about the ACCT process, but he wanted a medication regime that suited him. His risk remained assessed as raised, but the level of observations was reduced from four to three an hour.

46. That day, a nurse wrote in the man's medical record that a care plan had been put in place for when he returned to live on a houseblock. He would be expected to attend the medical centre to collect his medication twice a day and his evening medication would be taken to him. He would no longer receive any medication on demand. The nurse advised that if he threatened to harm himself, he should not be constantly supervised. He saw a psychologist that afternoon, but said that he would not accept different explanations about his need for pain medication or discuss alternative coping strategies.

47. On 22 October, a nurse recorded in the man's medical records that he had been observed walking with apparent ease and with no obvious stiffness in his upper back and neck. He had been seen taking a towel from the linen cupboard and he began to play fight with another prisoner. That evening, the nurse recorded that a member of staff had seen him in his cell scraping at his elbow. He said that he was cutting his elbow so he died and that staff did not care, as he had not seen a GP for three weeks. Officers removed a sharp object from his cell.

48. On 23 October, at 11.50am, a doctor and a nurse discussed the new care plan with the man and the decision to discharge him from healthcare and move him to a houseblock. The doctor recorded that he was unhappy with the proposed changes and became rude and shouted.

49. At 3.40pm, on 23 October, a SO held an ACCT review which an officer attended. A nurse did not attend, but had spoken to the SO beforehand and advised that there should be no change in the level of observations. At the review, the man maintained that his issue was about changes to his medication. He said that he currently had no thoughts of self-harm, but would harm himself if he was moved from the healthcare unit. The review assessed that he remained at a raised risk of self-harm and should still be observed three times an hour.

50. On 24 October, a multidisciplinary meeting was held to discuss the man and, in particular, what were described as his attempts to manipulate staying in the healthcare unit. A nurse recorded that the psychiatrist had suggested that, as

he had a diagnosis of a Munchausen's type of personality disorder, staying in the healthcare unit was not in his best interests. A doctor reviewed his case on 25 October and agreed the plan that he should move from healthcare to a cell on residential houseblock and that he should no longer get pain relief on request, but twice a day at scheduled times, from the medical centre.

51. On 25 October, the duty governor held an ACCT review which a nurse and an officer attended. The man said that the doctor had told him that he was going to be discharged from the healthcare unit. He said that he would kill himself at the first opportunity if he was moved, because he was not getting the right medication. The review concluded that he remained at raised risk of self-harm and the level of observation was unchanged at three times an hour.

52. After the ACCT review, the man went back to his cell and cut his wrist, using part of a cigarette lighter again. He refused to allow nurses to dress the wound and said that he was upset because the doctor had not told him about the changes being made to his medication regime.

53. On 26 October, a visiting psychiatrist reviewed the man and recorded that he was well known to mental health services and had a diagnosis of unstable personality disorder and Munchausen's syndrome. He said that he needed to stay in the healthcare unit as he could cope with the pain there and it was too noisy on a standard houseblock. He said that if he was discharged from the inpatient unit he would kill himself. The psychiatrist recorded that there was no medical reason for him to remain in the healthcare unit but a robust plan would be needed before he was moved to a houseblock.

54. On 28 October, the mental health team manager chaired an ACCT review attended by a custodial manager, a nurse, and two officers. The manager recorded that he had refused to attend as he said he was unwell. She noted that he had seen the doctor and psychiatrist and it was intended that he would be discharged from the healthcare unit. She recorded that he was now regarded as a low risk of suicide and self-harm and reduced the level of observation to two an hour.

55. At 4.30pm on 28 October, the man reported to a doctor that he had experienced pain around the scar of a previous operation since early in the morning, and that he had diarrhoea and had vomited some blood. The doctor sent him to the emergency department at hospital, where a doctor recommended several tests. He refused all treatment and tests and discharged himself. He returned to the prison by taxi with two officers. A prison doctor recommended that he should remain as an inpatient in the healthcare unit for a further 48 hours.

56. On 29 October, another ACCT review made no change to the risk assessment or level of observations. On 31 October a doctor reviewed the man, who said that he still had plans to kill himself and wanted a razor blade. He said that the psychiatrist had prescribed him zopiclone, which he said he had not received but the doctor told him that there was no record of this. The doctor said that he could be discharged from the healthcare unit if there was nothing adverse in his hospital discharge notes. A nurse spoke to the hospital later that day and was told that he had refused treatment. After he had seen the doctor, he told a nurse he had been prescribed zopiclone, which was not the case. The nurse

noted that his presentation and level of pain appeared very different when he was with other prisoners as opposed to nurses.

57. On 1 November, at 10.55am, the mental health team manager chaired an ACCT review (numbered case review 18) attended by a custodial manager, a SO from Houseblock 1, where it was planned to move him, a nurse and an officer. The man maintained that he was still in pain and did not want to be left in pain if he moved. He said that he would not harm himself if he stayed in the healthcare unit but he would kill himself if he went to a houseblock. The manager recorded that he had not self-harmed for over a week and had been in a good mood leading up to this review. The review discussed whether he should be constantly supervised because of his declared suicidal ideation, but observations were set at four times an hour and his risk was noted to be raised. An action was added to the caremap, that he should receive support on the houseblock through the ACCT process and have access to Listeners. He was moved to Houseblock 1 that afternoon.

58. An ACCT review was scheduled for 2 November, but we have not seen any documents relating to that review. Another ACCT review was held on 4 November, chaired by a SO and attended by another SO. There was no healthcare representation. The man said he was still in pain and, although he did not have any thoughts of harming himself at the time, he said he often felt like killing himself when the pain became too much. Despite this, the SO assessed the risk of further self-harm as low and reduced the level of observations to two an hour.

59. On 8 November, at 4.00pm, a SO held an ACCT review with the man. No one else was present, but the SO had spoken to a nurse by telephone before the review. The man said that he was still waiting for an orthopaedic mattress. He said he had no thoughts of suicide or self-harm, was happy to continue to sharing a cell and would consider taking up the opportunity of having a job in a prison workshop. As he had been settled on the houseblock for seven days, the SO assessed him as at low risk of suicide and self-harm and maintained the level of observation at two an hour.

60. A SO chaired an ACCT review on 13 November, attended by an officer. There was no healthcare representative. The man said he was still concerned about the changes in his medication and was waiting for an orthopaedic mattress. The SO spoke to a nurse by telephone, who agreed to follow up the issue of the mattress. He said that he had no thoughts of suicide or self-harm. His level of risk was assessed as raised but the level of observation was reduced to hourly while he was locked in his cell, with three conversations with him to be noted each day.

61. When interviewed, the SO said that, in retrospect, she probably should have assessed the man's risk as "no change" rather than raised. She added that she did not like "no change" as it did not mean a lot and she usually reserved "low" risk for ACCTs she planned to close. She told the investigator that she had arranged the next case review for a day she was on duty to provide some continuity. She said that he had settled well on the wing and had been seen interacting with other prisoners. She thought that he would be more vulnerable when he was locked in his cell than when he was with out of and set the level of

observations at once an hour when he was locked in his cell. She believed this was the same as previously, but in fact it was a reduction from twice an hour.

Events leading up to the incident

62. One morning an officer unlocked the man's cell. He noted in the ACCT document that he was up and dressed, and did not record any concerns. At 8.30am, an officer escorted him to the healthcare unit to collect his medication. The officer recorded in the ACCT document that there were no concerns and he was in good spirits.

63. At 9.25am, an officer recorded in the ACCT document that he had spoken to the man in his cell and he had told him that he felt well, had no concerns and was happy with the support he was receiving from staff. At 10.30am, the officer recorded in the ACCT document that he was sitting on his bed and watching television. At 11.35am, an officer unlocked his cell for lunch and recorded that he had not raised any concerns.

64. At 12.10pm, the man told an officer that he had just learnt that there had been a death in his family. He said he did not have any tobacco and asked for a smoker's pack (an emergency supply of tobacco that can be issued to prisoners). The officer said he did not have the authority to give him tobacco which would have to be agreed by an SO. He recorded what the man had said in the ACCT document and that he would see him after the lunch period once prisoners had gone to work. He noted that the man had said he was fine with this. He did not record that he had considered that the news about a family bereavement might have increased his risk of suicide or self-harm or that he had discussed this with the wing SO. (At the time the Governor and the Deputy Director of Custody for West Midlands were visiting the wing.)

65. The investigator interviewed Prisoner A who occupied the cell next to the man. He said that the man had shared a cell with a prisoner who, he believed, was Polish. The man's cellmate was at court that day so he was alone in his cell. The prisoner said that at lunch time the man had told him that his father had died. He asked him for tobacco, but he did not smoke so was unable to give him any. (After his death it was established that he had not had a family bereavement as he had claimed.)

66. An officer checked the man at 1.40pm and recorded that he was lying on his bed watching television. At 2.12pm, he went to speak to him as he had promised before lunch. When he opened the door, he found him hanging from the toilet door by a ligature made from a bed sheet.

67. The officer immediately radioed an emergency code blue. This alerts healthcare and other staff that a prisoner is unconscious or has breathing difficulties and should prompt the control room to call an emergency ambulance immediately. The control room log shows that the code blue call was made at 2.12pm. The ambulance service records show that the 999 call was also made at 2.12pm.

68. Prisoner A was first aid trained and, when he heard the officer radio for assistance, he went to see if he could help. He and another prisoner lifted the man's body while the officer cut the ligature. He was then lowered to the floor.

Prisoner A immediately began cardiopulmonary resuscitation (CPR). Two officers arrived shortly afterwards and took over CPR.

69. Healthcare staff responded immediately to the emergency call and took over the resuscitation attempt from the officers when they arrived. They used an automated external defibrillator (which monitors the heart rhythm and administers electrical shocks to restore the normal rhythm when necessary). The defibrillator advised that there was no shockable rhythm. Paramedics arrived at the cell at 2.22pm and took over from the prison staff. At 3.11pm the paramedics confirmed that the man had died.

Contact with the man's family

70. After the man's death, the Governor and a family liaison officer visited his sister, his nominated next of kin, to break the news in person and offer support. The prison maintained contact with the family to provide ongoing support and offered financial assistance towards the funeral expenses, in line with national guidance.

Support for staff and prisoners

71. A debrief was held the later in the afternoon of the man's death for staff involved in the emergency incident to discuss what had happened and to offer support. They were offered the services of the prison's care team. Officers and members of the chaplaincy supported prisoners affected by his death. Prisoners assessed as at risk of suicide or self-harm were reviewed in case they had been adversely affected by his death.

ISSUES

Assessment of risk

72. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners assessed as 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.

73. The man was subject to ACCT monitoring during his last two periods of custody at Hewell. When an ACCT was closed on 9 September, a post-closure interview was scheduled for 16 September. However, the interview was not completed as it should have been and was only completed after he had returned to prison. Post-closure reviews are important checks to ensure that the improvements that led to the ACCT being closed have been maintained and that there are no new issues that might raise the risk of suicide or self-harm.

74. On 3 October, an ACCT was opened because a doctor recognised that the man was at increased risk of self-harm or suicide. We believe that this was the correct assessment of the man's risk at that time. Subsequent case reviews usually had a member of the healthcare team present and, while he was in the healthcare unit, most of the reviews were led by either a nurse or the mental health team manager. We are pleased to note that a member of staff from Houseblock 1 attended the ACCT review before he was moved there. His major concern was about his medication and this was reflected in the caremap.

75. ACCT procedures once the man moved to Houseblock 1 do not appear to have been as well conducted. There were three (and possibly four) reviews held while he was on Houseblock 1 and each documented review was chaired by a different manager. Although his problems centred around his medication and his move from the healthcare centre and he had diagnosed mental health problems, there was very limited healthcare input into his ACCT reviews once he moved. One review had no healthcare input at all and, for the other two, the case manager spoke to a nurse by telephone. The review on 8 November consisted solely of the manager and him alone, which is poor practice. We do not consider that these reviews were appropriately multi-disciplinary.

76. At the review of 4 November, the man's level of risk of suicide or self-harm was assessed as low, a change from the previous level of raised at the review of 1 November. This was despite his assertion at that review that he wanted to kill himself when the pain got too much. At the review on 13 November, the SO recorded the level of risk as raised yet reduced the level of observations. The SO explained at interview that in hindsight she would not have changed the level of risk, but it is important that assessed risks on ACCT documents are accurately recorded.

77. We are also concerned that an officer did not take more immediate action when the man told him that he had suffered a family bereavement, only hours before he was found hanged. Although this turned out not to be true, we believe that if a prisoner is being monitored under an ACCT, information such as this should at least lead to some consideration about whether a multi-disciplinary review is

needed to review the level of risk and to help ensure that the prisoner remains safe.

78. While we have noted some areas for improvements in ACCT procedures, we recognise that it would have been difficult to foresee the man's actions in November. Although the level of observations had been reduced to one an hour, we note that the officer had checked on him approximately 30 minutes before he found him hanging so the change did not impact on his death. Nevertheless, the ACCT process is a fundamental part of keeping prisoners safe and needs to be used appropriately to be effective. We make the following recommendation:

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

- **A multidisciplinary approach for all case reviews;**
- **Assessing the level of risk and recording the reasons for decisions;**
- **Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;**
- **Holding appropriate post-closure reviews as scheduled.**

Clinical Care

79. The clinical reviewer noted that the man had a history of self-harm and manipulative behaviour which he used as a method of achieving certain goals. He found that healthcare staff had tried to ensure that his pain relief needs were met, but that they had difficulty doing this because of his behaviour and responses. He also found that the resuscitation attempt was conducted in line with national guidelines.

80. The clinical reviewer assessed that the man's mental health care was appropriate, accurate and well documented and that any changes in his behaviour, mood or actions were correctly recorded. A care plan was put in place for the management of his ongoing treatment and care when he was discharged from healthcare and moved to Houseblock 1.

81. Although the clinical reviewer's overall assessment was that the man's care was equivalent to what could have been expected in the community, he also found that there was no record that he had a physiotherapy appointment. As he had told a psychologist that he would not accept different explanations about his need for pain medication, or discuss alternative coping strategies, it is possible that he declined to see the physiotherapist but this is not recorded. Records indicate that a special mattress had been ordered for him on 24 September, but this was never received and there is no indication that the order was chased up, despite him reminding staff about this many times. We make the following recommendation:

The Head of Healthcare should ensure that specialist assessments and equipment which might help reduce a prisoner's level of pain are held and obtained promptly.

RECOMMENDATIONS

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

    - A multidisciplinary approach for all case reviews;
    - Assessing the level of risk and recording the reasons for decisions;
    - Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;
    - Holding appropriate post-closure reviews as scheduled.

2. The Head of Healthcare should ensure that specialist assessments and equipment which might help reduce a prisoner's level of pain are held and obtained promptly.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: a)A multidisciplinary approach for all case reviews; b)Assessing the level of risk and recording the reasons for decisions; c)Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes; Holding appropriate post-closure reviews as scheduled.	Accepted	Having reviewed the case management and how reviews are scheduled the following will be implemented – • Review Case management allocation and dedicate x2 case managers per prisoner – 1 Offender Supervisor and 1 Residential SO. • Timetable Reviews to be completed at dedicated times of the day to improve accountability and attendance. A degree of flexibility will be retained allowing to respond to the changing circumstances. This will be kept under review • Training to be developed highlighting any weaknesses in local ACCT process and targeting case managers • Guidance to be issued to all case managers regarding risk assessment in ACCT reviews. Guidance to include adjusting observation levels as to perceived risk changes. • Guidance to be issued regarding ACCT reviews ensuring that all held are multi disciplinary and include an input from healthcare. This is to be monitored through management checks and feedback through to	30/08/2014 Safety team	

			individuals involved.		
2	The Head of Healthcare should ensure that specialist assessments and equipment which might help reduce a prisoner's level of pain are held and obtained promptly.	Accepted	• Review assessment procedure ensuring pain management is appropriately managed • Review pain relief equipment ensuring that appropriate facilities are available for prisoners at HMP Hewell	30/09/2014 Healthcare	