A Report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man, a prisoner at HMP Manchester, in January 2014

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 died in hospital in January 2014 after being found hanging in his cell at HMP Manchester two days earlier. He was 33 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at Manchester was undertaken. Staff at Manchester co-operated fully with the investigation.

The man had been released on licence from a prison sentence in March 2013 but his licence was revoked and he was recalled to prison in October after he was charged with assaulting his partner. He cut his wrists later in October and was managed under suicide and self-harm prevention procedures, but for only two weeks. During his time at Manchester he completed alcohol, benzodiazepine and opiate detoxification programmes. Psychiatrists saw him several times about a previous diagnosis of post-traumatic stress disorder.

It appears that the man had difficulties in his relationship with his partner and friends of his said that he had been preoccupied about this. He was found hanging in his cell on the afternoon of 20 January 2014, less than an hour after an officer had told him that his partner had cancelled a planned visit that afternoon. Prison staff and paramedics administered cardiopulmonary resuscitation and he was admitted to hospital but, sadly, he died a few days later.

I am concerned that Manchester did not identify the man as a risk of suicide and self-harm when he first arrived at the prison. He had been recalled to prison after allegedly assaulting his partner, suffered from mental health problems and was withdrawing from alcohol and drugs. All of these are factors that increase the risk of suicide and self-harm and, indeed, he harmed himself just two weeks after arriving at Manchester. I am also concerned that staff did not consider all his risk factors when he was being monitored and, had this been done, it is possible he would have been actively managed and supported for longer. However, at the time of his death, I recognise that there was little to indicate that he continued to be at risk and staff were unaware of the difficulties in his relationship with his partner.

It is disappointing that Manchester did not have an emergency medical code protocol that was in line with mandatory national instructions and this led to a slight delay in calling an ambulance. I am also concerned that contact with the man's family was not as effective as it should have been.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2014**

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SUMMARY

1. The man was released on licence from HMP Risley in March 2013. During his sentence, he had been diagnosed with post-traumatic stress disorder and was on a methadone maintenance programme. He was recalled to HMP Manchester on 8 October, after he allegedly assaulted his partner. The man began detoxification programmes for alcohol and benzodiazepine dependence and continued a methadone maintenance programme. He was referred to the prison's mental health inreach team. Although he had a number of risk factors, suicide and self-harm prevention procedures (known as ACCT) were not initiated.

2. On 23 October, the man cut his wrist with a razor blade and an ACCT was opened. He said that he had cut himself because people he had considered his friends had made statements against him in court the previous day. He also said that he needed medication for his post-traumatic stress disorder. The ACCT was closed two weeks later after the man had seen a psychiatrist, but it is not apparent that his other risk factors were taken into account. A statement the man made to a prison chaplain about feeling "very bleak" due to the long sentence he might be facing does not appear to have been considered when he was reviewed.

3. Over the following weeks, the man completed his detoxification programme. A psychiatrist prescribed antipsychotic medication to seemingly good effect. Prison staff who knew him described him as a positive, polite man who did not cause any problems. However, his family were concerned about his safety and his mother said that she had spoken to a member of staff about this during her last visit, on 14 January 2014. We have been unable to identify this member of staff and found no record of any follow-up.

4. Prisoners who knew the man said that in the last few days of his life he was preoccupied by worries about his relationship. He was expecting a visit from his partner on the afternoon of 20 January but, at 1.30pm, an officer told him that she had cancelled it that morning. At 2.18pm, an officer found the man hanging by bed sheets attached to the grill behind his window. Prison staff and paramedics administered cardiopulmonary resuscitation and he was admitted to hospital. Sadly, he did not regain consciousness and died a few days later.

5. The investigation found that the man's risk factors for suicide and self-harm were not identified as they should have been when he first arrived at the prison. He was not managed under suicide and self-harm prevention procedures until after he cut himself. After that, he appeared to settle and there was little to indicate that he continued to be at risk and that he required further ongoing support. Manchester's local protocol for medical emergencies was not in line with mandatory Prison Service instructions, meaning that an ambulance was not requested automatically when an emergency code was called. We also found that liaison with the man's family could have been better. We make six recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and inviting anyone who had relevant information to contact him. No one responded.

7. The investigator visited Manchester on 27 January 2014 and saw the wing and cell where the man had lived. He spoke to four prisoners who knew him, including his cell mate. He met the Governor and the prison's family liaison officer. He was given a copy of the man's prison records.

8. The investigator interviewed seven members of staff at Manchester on 11 March and viewed CCTV footage of the man's landing during the events of 20 January. He interviewed a further two members of staff on 9 April. He gave feedback on the preliminary findings of the investigation and followed this up in writing to the Governor.

9. The investigator interviewed the man's offender manager and the prison's Head of Safer Custody by telephone.

10. NHS England commissioned a clinical reviewer to review the man's clinical care in prison. He joined the investigator for the visit on 11 March.

11. We informed HM Coroner for the City of Manchester of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted the man's cousin on 11 February, who represented the man's mother, his nominated next of kin. She raised the following issues that his family wanted the investigation to address:

    - He had cut his wrist in prison and, in phone calls, letters and visits with family members and his partner; he was vocal about wanting to end his life.

    - On his mother's last visit, his behaviour caused her to speak to a nun in the visits area, who said she would pass on her concerns.

    - Family members and his partner said that they telephoned the prison (but did not say when) to express concerns for his safety. They were told not to worry as he was on 'suicide watch'. His family were concerned that he was not being monitored before he died and believe that he should have been monitored more closely.

    - His family were not told that he was in hospital until the morning after he was admitted and thought that greater efforts could have been made to contact them the previous afternoon and evening.

- When they visited the prison after his death, his family met the Governor who, they said, was unable to answer their questions and did not know information they felt he should have done, such as why there had been a delay in informing them that he was in hospital. The prison would not allow their solicitor to attend the visit with them.

13. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP MANCHESTER

14. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. There is 24 hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Manchester was in September 2011. Inspectors reported that their most serious concern was the high number of self-inflicted deaths at the prison. They found that, while arrangements for caring for prisoners at risk of self-harm or suicide were not poor, there was room for improvement and the prison should be more proactive in learning lessons from previous deaths.

16. Inspectors found good relationships between staff and prisoners, although personal officer work was not fully effective and personal officer case notes were infrequent and lacked detail. They commented that the prison had introduced a fully integrated drug treatment system service and there were integrated mental health services.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their latest annual report, for the year to February 2013, the IMB reported that the prison was totally committed to safer custody and documents relating to the ACCT suicide and self-harm prevention process were completed to a high standard.

Previous deaths at HMP Manchester

18. We investigated four self-inflicted deaths at Manchester in the two years before the man died. We made several recommendations about the ACCT process and, in one investigation, we found that an ACCT document should not have been closed as some risk factors had not been taken into account.

Assessment, Care in Custody and Teamwork (ACCT)

19. 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 care map 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 care map have been completed.

KEY EVENTS

20. The man was sentenced to four years imprisonment in February 2011. He had previously served a shorter sentence in 2008. He was initially allocated to HMP Manchester and then moved to HMP Risley in April 2011. Other than a brief period at HMP Thorn Cross, he remained at Risley until he was released on licence on 11 March 2013. During his sentence he was initially on a methadone maintenance programme (as a substitute for heroin) which became a reduction programme as he progressed through his sentence. The man had been diagnosed with post-traumatic stress disorder as a result of a kidnapping incident when he thought he was going to be killed. He frequently saw the prison's mental health inreach team and was prescribed quetiapine (an antipsychotic medication). He was not regarded as a risk of suicide and self-harm at any point during this or his previous sentence.

21. After he was released from prison, a consultant psychiatrist assessed the man on 3 September 2013, and concluded that his presentation was consistent with a possible diagnosis of dissocial personality disorder (a personality disorder characterised by chronic antisocial behaviour) and post-traumatic stress disorder. The psychiatrist prescribed a course of sertraline, an antidepressant, although he later told prison healthcare staff that he had stopped taking this due to its side effects. The man continued his methadone reduction programme in the community.

22. On 8 October, the man was recalled to prison after he had allegedly assaulted his partner. He arrived at Manchester that afternoon. A healthcare assistant carried out a routine health screen in reception. The man explained that he had seen a psychiatrist in the community and had been diagnosed with post-traumatic stress disorder. He said he was currently prescribed quetiapine (although this was not the case at the time). He told the healthcare assistant that he was prescribed methadone, habitually used diazepam (a sedative) and drank heavily. She noted that the man was calm and polite and said he had no thoughts of harming himself or suicide.

23. A substance misuse nurse completed a withdrawal assessment on the man, which indicated that he required further assessment by the reception GP. The nurse also referred the man to the prison's integrated drug treatment system service (IDTS).

24. The reception GP then saw the man and referred him to the prison's mental health inreach team. The GP prescribed methadone in line with his current prescription (19ml per day) and chlordiazepoxide (a benzodiazepine medication used to manage the symptoms of alcohol withdrawal). The GP assessed that the man did not meet the criteria for benzodiazepine withdrawal treatment.

25. The man was taken to I wing, the prison's induction wing for newly-received prisoners needing substance use treatment. Shortly after he arrived on the wing, an officer carried out a first night assessment interview. The man raised no issues during the interview and, when asked, said he did not feel at risk of

suicide or self-harm. The officer remembered him from his previous time at Manchester and said he was a polite man who had never had any problems in prison.

26. The next morning, 9 October, prison doctor confirmed the details of the man's methadone and alcohol detoxification programmes with the man. Later a member of the prison's Substance Treatment and Recovery team (STAR, a team responsible for providing advice and counselling to prisoners undergoing drug treatment) interviewed him. The man said he was unhappy that he was not receiving benzodiazepines as he felt he needed them.

27. That afternoon, the man had a triage appointment with a prison mental health nurse. She detailed the psychiatrist's findings and noted that the man would be listed for review with a prison psychiatrist.

28. On 10 October, the man collapsed in his cell and healthcare staff assessed and treated him. The next morning an IDTS doctor reviewed him to assess the effectiveness of his detoxification programme. The doctor concluded that the man had symptoms of benzodiazepine withdrawal in addition to alcohol withdrawal. He therefore stopped the prescription for chlordiazepoxide and instead prescribed diazepam in line with guidelines for combined benzodiazepine and alcohol dependence. At a review on 14 October, the man said he had felt much better since this change.

29. The mental health nurse had a follow-up appointment with the man on 18 October when he told her that he felt uptight, had a poor appetite and had not slept, because of post-traumatic stress disorder. The nurse confirmed the man's upcoming appointment with the prison psychiatrist at which this could be discussed.

30. On 22 October, the man appeared in court and was remanded in custody until February 2014. At around midnight that night, he cut his right wrist using a razor blade. A nurse attended to clean and dress the wound and the night patrol officer on I wing opened an ACCT document. The officer recorded that the man would not say why he had cut himself. The custodial manager for H and I wings completed an immediate action plan and decided that he should be checked once every hour for the remainder of the night. The night patrol officer completed these checks and did not record any incidents.

31. An officer interviewed the man for an ACCT assessment on the morning of 23 October. He said he had been angry after his court appearance because people he had thought were his friends had given statements against him. He said this was what had prompted him to cut his wrist. The man also spoke about his history of post-traumatic stress disorder and that he hoped to get some medication for it. He said that he did not think he would harm himself again but could not be sure.

32. The I wing unit manager chaired the first case review later that morning. Seven people attended including the mental health nurse and a Supervising Officer. The man again said that he had cut his wrist out of frustration at the

statements made in court. He said that he had now come to terms with this and the manager noted that he was keen to progress within the prison regime. The man requested a medication review in relation to his post-traumatic stress disorder and was told that he had an appointment booked with the prison psychiatrist.

33. The unit manager completed a ‘care and management plan’ (caremap). He listed one issue, the man’s post-traumatic stress disorder. A medication review and referral to the prison’s mental health inreach team were identified as actions to address this.

34. Shortly afterwards a prison GP examined the man’s wound, which showed no sign of infection. The doctor discussed his previous psychiatric treatment with the man.

35. That afternoon the man moved to H wing, for prisoners receiving drug treatment who have completed their induction. In the evening he told two wing officers that he was happy to have moved from I wing.

36. In the ACCT document, staff frequently described the man as being in good spirits, polite and happy to chat with his cell mate or wing staff. The only exception was on 30 October, when he spoke to a prison chaplain and said that he was feeling very bleak because he could be facing a long sentence. The chaplain recorded this in the ACCT ongoing record and also noted that he strongly urged the man to tell someone if he thought of harming himself again.

37. A prison psychiatrist saw the man on 1 November. He explained his past experiences that had led to the diagnosis of post-traumatic stress disorder and said that he had stopped taking sertraline, as prescribed by the community psychiatrist, because it did not agree with him. He requested additional medication to control his anxiety and to help him sleep. The psychiatrist noted that he would see the man again two weeks later, when he had finished his diazepam detoxification, to consider starting an alternative antidepressant.

38. A custodial manager chaired an ACCT case review on 6 November, which the mental health nurse attended. The review team decided to close the ACCT plan at the review as the man had seen the psychiatrist and said his medication had been reviewed. The manager noted that he was also clear about what he needed to do to progress in the prison and had said that cutting his wrist was uncharacteristic and that he felt better able to cope. The manager told the investigator that the man had a positive attitude and good support from his family. No consideration was given at the review to the man’s previous statement that he felt very bleak about the long sentence he might be facing. The manager told the investigator that they did not discuss this issue as he was not due to be sentenced for some time.

39. The man finished his diazepam detoxification on 9 November. A follow-up appointment with the psychiatrist was booked for 11 November, but he did not

attend. No reason was recorded and he did not cancel the appointment through the prison's procedures. We note that the man had a visit from his family the same day.

40. On 14 November, a manager interviewed the man for an ACCT post-closure review. He said he was "stupid" to have cut his wrist and would not do it again. He also spoke of the support he received from his family. The manager concluded that there were no grounds to re-open the ACCT document.

41. The man missed a second follow-up appointment with the psychiatrist on 25 November. Again, no reason was recorded although we again note that he had a visit from his family that afternoon.

42. A further appointment was made for 29 November, which the man did attend. This time he saw a different psychiatrist. They discussed the man's history and medication. He said that he had previously taken mirtazapine, the antidepressant suggested by another psychiatrist, and found it unhelpful. He said he found quetiapine had helped him and asked for this to be prescribed. The psychiatrist agreed and prescribed a course for review in two weeks.

43. In early December, the man's partner wrote to the Governor to say that they were now engaged. She asked for permission to marry in the prison. The Governor replied on 11 December and explained the necessary procedures.

44. A psychiatrist reviewed the man on 16 December. The man said that his flashbacks had reduced, but he was still finding it difficult to sleep due to the anxiety from his past experiences. He said that quetiapine had helped him and asked for an increase in the dose to which the psychiatrist agreed. The psychiatrist told the investigator that he had agreed to increase the dose because he could see the improvement in the man's presentation since quetiapine had been prescribed by his colleague and he appeared much calmer.

45. On 23 December, an IDTS doctor reviewed the man and noted that his methadone detoxification was due to end on 26 December and he would like to finish it early. They agreed that he would complete the course as planned.

46. As the man had said that he was having trouble sleeping, a three night sleep watch (observation of the prisoner overnight to determine how they are sleeping) was initiated on 23 December. The conclusion was that the man appeared to be sleeping reasonably well.

47. The man was due to see a psychiatrist on 6 January 2014, but did not attend. The appointment was rebooked for 27 January.

48. During the afternoon of 11 January, the man spoke to a friend on the telephone. All prisoners' telephone calls are recorded and we listened to recordings of his calls. (Prison staff listen to a sample of telephone calls, but had not listened to his.) During the telephone call, his friend told the man that

his partner was seeing another man. The man telephoned his partner the next morning and spoke to her about the allegation which his partner said was not true.

49. The man had several visitors on 14 January, including his mother and his partner. His cousin, speaking on behalf of his mother, told us that his mother had spoken to someone who she described as a nun in the visits area during this visit as she had been concerned about her son. The investigator spoke to four female prison chaplains (one of whom is a nun and has since retired). None of them recalled speaking to her or any other member of the man's family at this or any other time.

50. On 17 January, the man spoke to his partner once in the morning and twice in the afternoon. They discussed the allegation made by his friend, and he said he was "pissed off" and had had "the worst week of my life". He was also upset because his partner's telephone often went straight to voicemail and therefore used up a lot of his credit. They agreed to speak again in the morning at 10.00am.

51. The man telephoned his partner at 9.58am on 18 January, but the call diverted to her voicemail. He tried to call three times in the afternoon and four times the next day, with the same result. Sometimes he left messages on his partner's voicemail. In the last message, at 2.22pm on 19 January, he said he was "gutted" that his partner had not answered the telephone but that he hoped to see her the next day when she had a visit booked.

52. At 9.00am on 20 January, the man's offender manager met him to help prepare a pre-sentence report for the court. They discussed the potential sentence that he might receive. One action was an indeterminate sentence for public protection (where the court sets a minimum term of imprisonment, after which the offender will be released once they can satisfy the Parole Board that their risk of reoffending has sufficiently reduced) or a determinate sentence (where the court sets a fixed length of sentence after which the offender is automatically released on licence). The offender manager told the investigator that the man understood that both options were available to the court. They also discussed his relationship with his partner. He recalled that the man was upbeat about this and looking to the future. He said that he had had no concerns for the man's at this meeting.

53. The man returned to H wing after the meeting. A friend of his from the neighbouring cell, Prisoner A, remembered seeing the man at around 11.45am and said he was joking around and seemed all right. An officer spoke to the man at around 12.00pm when he returned to his cell after collecting lunch. He said that the man had joked about the menu and did not appear to have any issues.

54. During the morning, the man's partner telephoned the prison to cancel her visit that was booked for that afternoon. No one told the man at the time.

55. Shortly before 1.30pm, an officer went to H wing to collect prisoners who had visits scheduled for the afternoon. These included the man's cell mate. The officer unlocked their cell at 1.28pm to collect the cellmate and told the man that his partner had cancelled their visit. The officer said that the man was initially a little upset but no more so than any other prisoner might have been in the circumstances. However, the cellmate told the investigator that the man was "gutted" when told that his visit was cancelled. The man asked the officer for permission to leave the cell and visit his neighbours so he could borrow cigarette papers. He was out of the cell for around one minute and went to two neighbouring cells.

56. At 1.35pm, an officer went to the cell to ensure that the man's cellmate had left for his visit. He opened the door for just a few seconds to check and saw him sitting on a chair at the table. The officer said they did not engage in conversation and he did not see anything that gave him cause for concern.

57. At around 2.15pm, a mental health nurse arrived on H wing to see the man as part of his mental health follow up. At the time two officers were on the man's landing. Officer A went to his cell to unlock him. Closed circuit television (CCTV) footage shows that he arrived at the cell at 2.18pm. When he opened the cell, he found a cupboard had been placed between the bed and desk and this obscured his view into the cell. He saw a piece of cloth that appeared to be attached to the window bars, but could not see the man.

58. Officer A shouted for assistance and several officers ran to the cell. Officer B was first to arrive and helped Officer A to move the cupboard sufficiently to allow him to get past it and attend to the man. CCTV footage shows that 27 seconds elapsed between Officer A arriving at the cell and Officer B moving the cupboard onto the landing. Officer A found the man slumped against the back wall and heating pipes, hanging from a ligature made from a bed sheet which was attached to the grill outside the window. Officer A then supported his weight while Officer C cut the sheet using her anti-ligature knife. They laid the man on the cell floor and Officer A began cardiopulmonary resuscitation (CPR).

59. A manager was one of the first members of staff to arrive at the cell and made a 'priority one' radio call (the current emergency code at Manchester indicating a life-threatening situation). A nurse heard Officer A's initial call for assistance from her office just off H wing. She established that the man had been found hanging, ensured that CPR had begun, and went to fetch the emergency bag (including emergency response equipment such as a defibrillator), which is kept on the first floor landing in the central area just outside H wing. She returned to the cell at 2.20pm.

60. At around the same time, the manager took over CPR from Officer A. The nurse applied the defibrillator, which found no shockable heart rhythm and advised them to continue CPR. At 2.22pm, an SO radioed to request an emergency ambulance. The first response paramedic arrived at the cell at 2.38pm and took over CPR. An ambulance crew followed around ten minutes later. At 3.20pm, the man was taken by ambulance to hospital, after

paramedics had established a pulse. Two officers escorted him and restraints were not used.

61. At 4.11pm, the prison's family liaison officer tried to telephone the man's mother, who was listed as his next of kin. His mother lives in the Republic of Ireland. The family liaison officer told the investigator that there was a delay as she was initially unable to find a telephone in the prison that allowed international calls. She eventually called from the prison's communication room. She said that she tried to telephone eight times, but did not get an answer. The man's mother disputes that she tried that many times. The family liaison officer spoke to the deputy governor and they agreed that they should ask the Irish police to go to see the man's mother.

62. By the next morning, the prison had not received confirmation from the Irish police that they had spoken to the man's mother. The family liaison officer spoke to the Head of Safety and Equality at Manchester, and agreed that she should contact the man's cousin in the United Kingdom. The family liaison officer spoke to the man's cousin at around 8.20am and explained what had happened. The man's cousin spoke to the man's mother shortly afterwards, who had by this time been visited by the police. Several members of the man's family, including his mother, flew to Manchester that day and arrived at the hospital in the afternoon.

63. The man did not regain consciousness and, at around 10.00pm that night, he was declared brainstem dead. He was kept on a life support machine so other relatives could visit and to preserve his organs for donation. The life support machine was switched off on the evening of 22 January and the man was formally declared dead at 10.00pm. A post-mortem examination established the cause of death as hanging.

64. The man's cell mate told us that he was very well supported by wing officers after the death. Prison and healthcare staff who were involved in the events of 20 January also said that they received appropriate support from managers.

65. The man's family visited HMP Manchester on 31 January. His funeral took place on 5 February and the prison contributed towards the costs in line with national guidance.

ISSUES

The man’s risk of suicide and self-harm

66. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner’s known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 states that “all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action”. A list of risk factors includes previous deliberate self-harm, mental illness, early days in custody and offences particularly those charged with violence against another person, especially against family members or partners, substance misuse or detoxification including from alcohol is noted as a trigger which can increase the risk.

67. When he arrived at Manchester on 8 October 2013, a number of these factors applied to the man. He had been recalled to custody and charged with an offence of violence against his partner. He had been diagnosed with post-traumatic stress disorder, was withdrawing from alcohol and opiates and was also a user of benzodiazepines. The man was open about these factors at reception, yet none of the reception staff considered he was at risk of suicide or self-harm or discussed the risk factors with each other.

68. We note that the man had not previously harmed himself in prison. However, he presented with a range of risk factors and we consider it would have been prudent to open an ACCT when he first arrived at Manchester and to have continued to manage him under ACCT until staff were satisfied he was stable and settled on his medication. Reception staff should have been aware of these risk factors but there is no evidence they were considered. We make the following recommendation:

    The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

    - **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
    - **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs and open an ACCT when indicated.**

69. Officers began managing the man under ACCT procedures on 23 October, after he cut his wrist with a razor blade. The man explained that the motivating factor behind this was that he had felt let down by friends who had made statements against him in court the previous day. He also said he hoped for a medication review for his post-traumatic stress disorder. There

were no further incidents of self-harm or any additional issues identified during the two weeks that the ACCT was open. During this time, the man saw a psychiatrist and discussed his medication. He had requested additional medication, for anxiety and to help him sleep, but the psychiatrist had decided he needed to complete his diazepam detoxification before starting an alternative antidepressant. While it might have been more prudent to have continued to keep the ACCT open until the man's medication had been settled, the case review held on 6 November regarded his caremap action to have a medication review as completed and closed the ACCT.

70. While the reasoning behind the decision to close the ACCT is understandable, based on the caremap action, we are concerned that the review panel did not consider and discuss a statement the man made to the chaplain on 30 October. This was recorded in the ACCT document and noted that he was feeling "very bleak" due to the sentence he might be facing. The custodial manager, who led the review on 6 November, said they did not discuss this as the man was not due to be sentenced for some time. However, his comment suggests that the prospect of such a sentence was a significant issue for him at the time and we believe that it should have been explicitly addressed with him before the ACCT was closed. We make the following recommendation:

The Governor should ensure that ACCT reviews consider and discuss all relevant information which might affect a prisoner's risk.

71. The man's family thought he continued to be at risk when the ACCT was closed and they said that he clearly intended to end his life. They thought that he should have been supported and monitored more closely. The investigator spoke to prisoners who knew the man and they said he was not suffering from any problems within the prison, such as bullying or debt. Prison staff described him as being a polite man who worked hard and never caused any problems and, as far as they were aware, was not troubled by any issues. The wing manager said that the man spoke to him about his relationship and said that he was concerned that this might end if he received a long sentence, but added that he was a positive person and he did not think there was any risk that he might harm himself. While some of the underlying risk factors remained, others had abated over time, such as the man's successful detoxification and we did not find any other significant evidence that might have indicated to prison staff that he was at further risk at the time or that the ACCT should have been reopened.

72. Prisoners who knew the man said that his demeanour changed in the last few days of his life as he began to worry about his relationship. His cell mate said this was particularly the case after 17 January as he had been trying to speak to his partner on the telephone but was unable to get through. None of the members of staff we spoke to said they noticed anything untoward or saw anything further that concerned them during this time.

Concerns raised by the man’s mother during her last visit

73. The man’s mother said she was worried by her son’s behaviour on her last visit and that she spoke to a woman in the visits area because she was concerned about his safety. She described the lady she spoke to as a ‘nun’.

74. The man’s mother’s last recorded visit was on 14 January 2014. The investigator spoke to the three women chaplains who currently work at Manchester, as well as a recently retired chaplain. (The recently retired chaplain is a nun, but none of the women chaplains currently working at the prison are nuns.) None of them recalled speaking to his family on 14 January or at any other time.

75. The Head of Safety and Equality at Manchester told the investigator that if concerns are raised by a visitor, the group that runs the visits centre should telephone the safer custody team. They log the call and contact the prisoner’s wing to ask them to check the prisoner. There was no call logged that related to the man.

76. It is vital that families of prisoners are able to raise concerns for a relative’s safety and be confident that action will be taken as a result. We have been unable to confirm to whom the man’s mother spoke during her visit. However, if she did raise concerns, they were not recorded or acted upon. We believe that the Governor should take this opportunity to ensure that this process is working effectively and we make the following recommendation:

    The Governor should ensure that any concerns relating to a prisoner’s safety which are raised by a visitor are appropriately recorded and followed up.

Clinical and mental health care

77. The clinical reviewer completed a review of the man’s clinical care in custody. He found that his detoxification medication was administered appropriately, although changes to his methadone prescription should have been better recorded.

78. The man had previously been diagnosed with post-traumatic stress disorder and he was concerned about the prescription of medication for this in his first weeks at Manchester. A psychiatrist said that he was much calmer once prescribed quetiapine and had said himself that the medication had helped. The clinical reviewer was satisfied that he was prescribed appropriate medication for his mental health needs.

Emergency response

79. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes,* issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a

medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called.

80. A manager promptly called a ‘priority one’ radio call for medical assistance. The local policy at Manchester states that this code is to alert the response nurse that there is a medical emergency and, in contrast to the national instruction, indicates that an additional request must be made for an ambulance. He told the investigator that he was not aware of this and expected that his priority one call meant that an ambulance would be called. As it was, a separate radio call was made to request an ambulance three minutes later. Even such a short delay can have a significant impact on a person’s chance of survival in a life threatening situation and we are concerned that Manchester’s local instructions were at odds with mandatory national requirements.

81. Since the man’s death, Manchester have amended their local policy to instruct that an ambulance should be called whenever a priority one call is made. However there is still variation from national policy as the priority one code does not allow differentiation between different types of injury as is required. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Manchester has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

Family liaison

82. The man’s family are concerned about the communication they had with the prison after he was admitted to hospital and after his death. His mother was told of her son’s hospital admission on the morning of 21 January and thought that more effort should have been made to contact her the previous afternoon and evening. The man’s family was unhappy with the arrangements for a prison visit after his death, as their solicitor was not permitted to accompany them and they considered a number of their questions were not answered.

83. The prison’s family liaison officer first attempted to telephone the man’s mother at 4.11pm on 20 January, but received no answer. She said there was a delay because at first she was unable to find a telephone in the prison

which allowed international calls. Since his death, telephones in the safer custody office have been set up to allow international calls.

84. The family liaison officer said that she tried to telephone eight times without answer and was unable to leave a message as there was no voicemail facility. She recorded this in the Family Liaison Officer log, although this was not provided until after we issued our draft report. The man's mother disputes the family liaison officer's version and said that only one call was made, which she was unable to take, and that she has a voicemail facility on which no message was left. As the family liaison officer was unable to speak to the man's mother, she asked the Irish police to visit her. They did so the next morning, around the same time that she spoke to the man's cousin.

85. We are unable to say whether the family liaison officer's or the man's mother's version of events is correct, but we would expect prison staff to make several attempts to contact the next of kin before alternatives are considered and to record this in the Family Liaison Officer log. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies or is seriously ill. We agree that it was appropriate to ask the Irish police to contact the man's mother after the prison's attempts to do so proved unsuccessful. However, the prison should not then have waited until the following morning for confirmation that the police had visited, but should have made further attempts to ensure that his family was aware of what had happened. We make the following recommendation:

The Governor should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.

86. It is clear that the man's family are unhappy with the outcome of their visit to the prison on 31 January 2014. The family liaison officer explained that their solicitor was not admitted to the visit because the meeting with the Governor was for him to offer his condolences rather than in-depth questioning. At the same time, the family were unhappy as they felt that many of the questions they asked at this meeting were not adequately answered and the Governor did not know of some issues, such as the delay to informing them that the man was in hospital.

87. PSI 64/2011 is the Prison Service instruction that gives guidance about safer custody and family liaison after a death in custody. The only guidance given about a visit by the family to the prison after a death in custody is that the family liaison officer should facilitate the family's wishes to visit the scene. We believe that the purpose of the visit is intended to be pastoral – for prison staff to offer condolences and support to families. However, the guidance also says that all families are different and will have different needs. Ultimately, it is for the Governor to decide who to allow in to the prison. In this case, he believed that the presence of a solicitor might interfere with what the prison believed was the purpose of the visit. In doing so, however, they did not meet the needs of the man's family and this seems to have fostered some distrust.

88. The man's family believed that they did not get the answers they wanted when they visited the prison. Grieving families will understandably be very distressed after the death of a loved one and we appreciate that at an early stage it can be very difficult for prisons to provide all the answers to their questions. Some questions might need to wait for the PPO investigation and then the inquest process before they are answered. Even when prisons have the answers, bereaved families might find them difficult to accept, so good communication is essential. The family do not feel that they were given answers to questions which the prison should have been able to provide and that they did not think that the Governor was aware of their concerns about the delay in contacting the man's mother.

89. In response to our draft report, the Governor said that when he met the man's family he was clear about the delay to contacting them and explained that this was unacceptable. He said that the only questions they were unable to answer related to burns on the man's body.

90. PSI 64/2011 gives a mandatory instruction that the family liaison officer should be familiar with the details of the death and the prisoner's history. It emphasises that 'it is vital that accurate information about the prisoner's death is given to the next of kin' and notes that 'inaccurate information at this stage can cause unnecessary distress and suspicion and undermines the prison's ability to build a relationship with the family'. We agree that it is important that any member of staff meeting a bereaved family should know the relevant details and be able to answer straightforward questions about the circumstances of the death and account for the subsequent actions of the prison. We are unable to say exactly what was discussed at the family's visit to the prison, but it is clear that they were dissatisfied with the outcome. We make the following recommendation:

    The Governor should ensure that he and all prison staff who meet the families of deceased prisoners are fully aware of the circumstances of the death and, so far as possible, are able to provide families with accurate answers to their questions.

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

   - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
   - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs and open an ACCT when indicated.

2. The Governor should ensure that ACCT reviews consider and discuss all relevant information which might affect a prisoner's risk.

3. The Governor should ensure that any concerns relating to a prisoner's safety which are raised by a visitor are appropriately recorded and followed up.

4. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Manchester has a Medical Emergency Response Code protocol which:

   - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
   - Ensures staff called to the scene bring the relevant equipment; and
   - Ensures there are no delays in calling, directing or discharging ambulances.

5. The Governor should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.

6. The Governor should ensure that he and all prison staff who meet the families of deceased prisoners are fully aware of the circumstances of the death and, so far as possible, are able to provide families with accurate answers to their questions.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff: • Have a clear understanding of responsibilities and the need to share all relevant information about risk. • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs and open an ACCT when indicated.	Accepted	All Reception staff and first night staff will be briefed and local guidance will be issued around the identification or risk factors. In addition, safer custody staff will be available on the first night centre to help staff co-ordinate and share information. All staff working at HMP Manchester have received ACCT training and RAPPS training (reducing and preventing prison suicide – this training is available in the High Security Estate) has been delivered to a number of reception and first night staff. This training specifically looks at the identification of internal and external risk factors. The safer custody team regularly review the quality assurance process and will update it to include auditing the presence of recorded risk factors. All ACCT case managers and staff in target areas will be given briefing on the importance of recording risk factors. All known risk factors are currently recorded on SystmOne, PNOMIS, Mercury, PNC, Core Records and CSRA assessments. The reception health screen has been amended to reflect certain risk factors. Guidance will be reissued to staff to remind them of the importance of recording and	30th September 2014 30th March 2015	

			methods of sharing information.		
2	The Governor should ensure that ACCT reviews consider and discuss all relevant information which might affect a prisoner's risk.	Accepted	We have introduced post closure audits on the quality of the review summary and risk factors in the ACCT documents. Advice and feedback will be given to managers.	Completed	
3	The Governor should ensure that any concerns relating to a prisoner's safety which are raised by a visitor are appropriately recorded and followed up.	Accepted	A number of mechanisms in place for families to raise their concerns. Information recording and sharing arrangements with Partners of Prisoners and Families Support Group (POPS), chaplaincy and safer custody have been strengthened. Management checks will be put in place to ensure the effectiveness of information recording and sharing.	30th September 2014	
4	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Manchester has a Medical Emergency Response Code protocol which: • Provides guidance to staff on efficiently communicating the nature of a medical emergency; • Ensures staff called to the scene bring the relevant equipment; and • Ensures there are no delays in calling, directing or discharging ambulances.	Accepted	The new emergency protocol is in place and has been checked through internal contingency tests to ensure compliance.	Completed	
5	The Governor should ensure that next of kin are notified as soon as possible	Accepted	We will review our procedures for next of kin contact and brief all Family Liaison Officers	30th June 2014	

	when a prisoner becomes seriously ill.		(FLOs) on arrangements for contacting next of kin		
6	The Governor should ensure that he and all prison staff who meet the families of deceased prisoners are fully aware of the circumstances of the death and, so far as possible, are able to provide families with accurate answers to their questions.	Accepted	We will ensure that all FLOs brief the governor following a death in custody in a formal briefing meeting to ensure that all information provided is both consistent and accurate.	Completed	