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 at HMP The Mount in May 2013

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 to have hanged himself in a cell in the segregation unit at HMP The Mount in May 2013. He was 44 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer reviewed the man's clinical care. The Mount and HMP Risley, where he had previously been held, cooperated fully with the investigation.

The man was serving an indeterminate sentence and was some years past his minimum term. He had a history of attempted suicide and mental health problems. In April 2013, because of concerns about his mental health and his level of risk, he was moved back from an open prison from which he was hoping to be released, to closed conditions at HMP Risley. He attempted to take his own life and was monitored constantly under suicide and self-harm prevention procedures for seven days. He then appeared to settle but, on 14 May, he was unexpectedly transferred back to The Mount, the prison he had moved from in February 2012. He had enhanced status under the Prison Service incentives and earned privileges scheme but this was not recognised or checked by reception staff at The Mount. In protest, he refused to go to the prison's induction unit and was taken to the segregation unit where he died within three hours of his arrival.

I am concerned that a rigid population management policy resulted in the man being transferred back to The Mount without a clear consideration of whether this met his individual needs. Staff at Risley did not assess whether the transfer might make him feel suicidal again and did not pass on to The Mount detailed information about his recent suicide attempt and what had triggered it. The man's risk was not properly assessed when he arrived at The Mount and prison reception staff were diverted by the dispute over his privilege status but did not resolve the situation. He was then treated as a discipline problem rather than a prisoner who might be vulnerable and at risk. When he was in the segregation unit a routine hourly check was missed.

When the man was found unresponsive, resuscitation attempts began rapidly and ambulance staff arrived quickly. However, the prison staff involved were unclear about responsibilities, did not use an appropriate emergency code and were unaware where essential emergency equipment was kept. It is not evident that this affected the outcome in this man's case, but in other incidents it could be crucial. There is a clear need for The Mount to implement appropriate emergency response procedures about which all staff are aware.

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 **June 2014**

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SUMMARY

1. The man was convicted on 13 July 2007 of wounding and given an indeterminate sentence with a minimum of 3yrs and 3 months to serve in prison. He had a history of mental health problems and self-harm. He spent some time at The Mount, and then moved to a resettlement prison, HMP Kirklevington Grange, in February 2012. After he went on hunger strike, he was considered unsuitable to remain there and was transferred to HMP Holme House in May. In June, he moved to HMP Kirkham, an open prison. Towards the end of 2012, he was monitored as a risk of suicide and self-harm for two periods.

2. The man was moved back to closed conditions at HMP Risley from Kirkham on 5 April 2013, as there was concern about his risk. Immediately before his transfer to Risley, he attempted to take his own life and was again monitored as a risk of suicide and self-harm. He remained constantly supervised in the segregation unit at Risley until 11 April and then moved to the induction unit on 12 April, where he appeared to settle well. He was no longer monitored as a risk of suicide and self-harm.

3. In May, the man returned to The Mount. Staff at Risley did not send details about his history of self-harm and mental health problems. Although his risk of self-harm had been noted on the Person Escort Record (PER) which accompanied him, staff at The Mount did not act on this. During the reception process at The Mount, the man was told that his status under the incentives and earned privileges scheme had been recorded as standard, rather than enhanced and that he was therefore not allowed to have his own clothes or bedding as he had previously been allowed. He knew this to be incorrect. He became upset and agitated and refused to cooperate, including with his initial reception health screen. Prison staff were unable to persuade him to go to the induction unit and he asked to be taken to the segregation unit.

4. In the segregation unit, the man refused to dress in prison issue clothing and remained in his underwear, with a blanket. A nurse assessed him as suitable for segregation, although she had not seen his medical records. A segregation unit officer checked him at 5.00pm but a further expected hourly check did not take place. At 6.55pm, during a roll check, an officer found him slumped at the back of his cell, with a shoelace tied around his neck. She radioed for immediate assistance but did not use an emergency code. Officers attempted to resuscitate him. An ambulance was called and paramedics took over the resuscitation attempt when they arrived. However, at 7.40pm, attempts to revive him were stopped and he was pronounced dead.

5. As the man's family live in Scotland, the prison asked the local police to inform his family of his death. The prison offered a contribution towards his funeral costs.

6. The investigation found that the transfer from Risley did not take into account the man's needs and vulnerability and Risley did not sufficiently communicate

information about his risks when he moved to The Mount. Staff at The Mount did not consider the risk of self-harm indicated on the PER document or make appropriate checks to establish his incentives and earned privileges status when he disputed it. Hourly monitoring did not take place in the segregation unit as expected and there was a lack of understanding about appropriate emergency procedures.

THE INVESTIGATION PROCESS

7. Notices about the investigation were issued to staff and prisoners at The Mount, inviting anyone with relevant information to contact the investigator. Two prisoners came forward.

8. The investigator visited The Mount on 16 May 2013 and met staff and a member of the Independent Monitoring Board. She obtained copies of the man's prison records and visited various parts of the prison, including the segregation unit. On 21 May, the investigator visited HMP Risley, the man's previous prison, and obtained additional documents. She later interviewed staff at both prisons.

9. NHS East of England appointed a clinical reviewer to conduct a review of the care the man received at The Mount and Risley.

10. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post-mortem report. The investigation report has been sent to the Coroner.

11. One of the Ombudsman's family liaison officers spoke to the man's sister about the investigation process. She asked the investigation to cover the reason for her brother's move to The Mount and why his clothes were taken from him when he arrived there, leaving him with just his shoes and underwear.

12. The man's family received a copy of the draft report. Their solicitor wrote to us with a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP THE MOUNT

13. HMP The Mount in Hertfordshire is a medium security prison which holds up to 800 adult male prisoners. Healthcare services are commissioned by Hertfordshire Community Care Trust. Healthcare staff are not on duty after 6.30 pm on weekdays and after 5.00 pm at weekends.

HM Inspectorate of Prisons

14. The Inspectorate carried out a short follow-up inspection of The Mount in October 2011. Inspectors found that the prison had made good progress addressing the healthcare recommendations made at the previous inspection in 2009. Insufficient numbers of staff had received ACCT training. The segregation unit was clean with an adequate regime, but there were no care-planning documents for prisoners in the segregation unit as the Inspectorate had previously recommended and all prisoners entering the unit were strip searched without a risk assessment to justify it. There was a comprehensive incentives and earned privileges (IEP) policy, although inspectors noted that there was confusion about prisoners retaining enhanced status on their arrival and recommended that prisoners who had been on the enhanced level at their previous prison should retain that status on arrival at The Mount.

Independent Monitoring Board (IMB)

17. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In its most recent annual report, for the period to February 2013, the IMB were concerned that proposed staffing levels would be inadequate at times of stress. The IMB said that this had already been evident in the segregation unit and that excessive pressure was placed on the segregation unit staff when the segregation unit was near capacity.

Previous deaths at The Mount

18. We have investigated four deaths at The Mount since 2007. All four were from natural causes. There are no similarities between these and this man's death.

HMP Risley

19. HMP Risley is a medium security training prison which holds over 1,000 adult male prisoners. Healthcare services are commissioned by Warrington Primary Care Trust (PCT). There is 24 hour healthcare cover.

20. The last inspection of Risley was in February 2011. HMIP found that Risley was a safer, cleaner and more decent prison than when it was last inspected in 2008. It described Risley as a nicer place to be for prisoners and staff, that relationships between the prison and NHS agencies were good, with a range of primary care and life-long condition clinics. There were low levels of self-harm and those at risk were identified and monitored at an early stage.

However, gated cells for prisoners needing constant supervision were inappropriately located.

Assessment Care and Custody Teamwork (ACCT)

21. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

Incentives and Earned Privileges (IEP) Scheme

22. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

KEY EVENTS

23. The man was convicted of grievous bodily harm with intent on 13 July 2007. He was given an indeterminate sentence for public protection, with a minimum time to serve in prison of three years and three months (known as the tariff) and taken to HMP The Mount. He had a longstanding history of mental health problems and self-harm and had made several reported suicide attempts. He had previously been in the army and had threatened suicide by placing a rifle in his mouth when he had lost privileges after disciplinary proceedings. Before he went into prison, he has been under the care of mental health services who had diagnosed depression, anxiety and agoraphobia, with mildly low mood and a personality disorder. He also had a history of substance misuse.

24. Towards the end of 2007, hospital specialists assessed the man and concluded that, although he had a moderate number of symptoms associated with post traumatic stress disorder, he did not meet the criteria for a formal diagnosis. After psychiatric tests in early 2008, he was diagnosed with a generalised anxiety disorder.

25. The man progressed well at The Mount and was recognised as suitable for open conditions and his security category was reduced to D – the lowest level of risk. He transferred to HMP Kirklevington Grange, a resettlement prison, on 7 February 2012, where he remained for three months. During that time, he re-established contact with his family and two daughters. However, he was moved to HMP Holme House after he began a brief hunger strike in May about access to healthcare services. On 14 June 2012, he transferred to HMP Kirkham, an open prison in Lancashire. He said he wanted to remain at a prison closer to his home and family in Scotland.

26. At Kirkham, the man was referred to the mental health in-reach team as he had often reported suffering from post traumatic stress, arising from some of his experiences in the army. He was also referred to a support organisation that helps ex-servicemen to combat stress but there is no record that he had any contact with them. Between 7 and 20 November, he was monitored under the ACCT process (Prison Service suicide and self-harm procedures) after he told his drug worker he had thoughts of suicide. He also said he was stressed about family issues, work and a forthcoming parole hearing. He was monitored under ACCT procedures again from 22 November to 2 December. He believed that there was a personal vendetta against him as he had been moved from a room in the substance misuse unit to a room elsewhere in the prison, which he said was damp.

27. In February 2013, the man did not attend his work placement in the community and the Parole Board deferred his hearing until June 2013. On 11 March, he started a week long period of release at a Probation Service approved premises in London, with a view to living there after his possible parole in June. However, he returned to the prison a day later as he did not like the accommodation. He was dissatisfied with the arrangements subsequently proposed by his offender supervisor, including a return to the

approved premises and believed she was setting him up to fail by putting him in high risk situations. His attitude and behaviour was reported to have deteriorated and he was said to have been aggressive towards his offender supervisor and other staff. Staff were concerned about the potential impact on his forthcoming parole hearing in June and considered it was difficult to manage his resettlement at that time.

28. A risk management meeting was held at Kirkham on 4 April. The outcome was that the man should be returned to closed conditions owing to concerns about the potential risk to his offender supervisor; a deterioration in his mental health, wellbeing and coping skills; his failure to engage with the mental health services; and his refusal to comply with his sentence planning by leaving his work and accommodation in London. It was agreed that his risk was too significant to manage in open conditions and it was recommended that he receive a period of mental health work and assessment to address his anger management and demonstrate a period of stability before returning to an open prison open conditions in the London area.

HMP Risley

29. On the morning of 5 April 2013, staff at Kirkham began to process the man's transfer to HMP Risley and took him to a holding cell. He had not been aware of the impending transfer and tried to take his own life that morning by placing a pillow case over his head and twisting it around his neck.

30. Because of the man's suicide attempt, an officer opened an ACCT to monitor him under suicide and self-harm prevention procedures. He was adamant he would take his own life by any means and mentioned a number of methods he could use. He told officers he did not want to spend any more time in prison as he was three years over his tariff. He believed he had been 'set up to fail' and was concerned that he would not be released at his next parole review. He said that he had started a hunger strike from the previous evening. He was assessed as high risk of self-harm and constantly supervised. A further review was set for the next day.

31. The man then transferred to Risley. Staff at Kirkham sent the appropriate documents, including an 'Annex Q form', from the safer custody department which notifies receiving prisons of a prisoner who is at risk of suicide and self-harm and sets out the details of events and perceived risks.

32. An immediate ACCT review took place when he arrived at Risley at 2.30pm. He reiterated his intent to take his life and was assessed as high risk. As part of this review, a caremap action plan should have been completed to reflect his needs, level of risk and triggers of his distress, but this was not done. At the review, the man explained that he felt let down by individuals within the prison system and said it was pointless to engage with staff. He said that he felt very isolated and had given up hope that his life would improve. He refused to take food or fluids or cooperate with the induction process. He refused to go to a safer cell on D wing so was constantly supervised in a gated cell, in the segregation unit.

33. That afternoon, a nurse conducted the man's initial health screen. She recorded that he appeared stable but was angry with the system. He said he intended to take his own life and could not stand another day in prison. She referred him to the mental health team.

34. During an ACCT review on 8 April, the man said he still wanted to die. He was emotional but began to engage with staff and agreed to speak to a member of staff who had been in the army and dealt with veterans. There is no record that this happened. His risk level remained assessed as high and he continued to be supervised constantly.

35. A further ACCT review took place on 11 April, which noted a vast improvement in the man's demeanour, due to renewed contact with his family and engagement with staff. He said he felt better, no longer had thoughts of suicide and wanted to move to a normal wing. His observations were reduced from constant supervision to one each hour. The next day, a custodial manager and a chaplain held a further review. They noted that he had made a lot of progress over the previous week. He had a positive attitude and thoughts and they discussed a move to the induction unit on D wing. The man's ACCT was closed that day, 12 April, and a move to D wing was arranged. A post-closure review was set for 19 April but there is no record that this took place.

Events between 12 April and 14 May

36. The man moved to a single cell on D wing on 12 April. He appeared to settle well and was allowed his own clothing and bedding as he was on the enhanced level of the incentives and earned privileges scheme.

37. A community psychiatric nurse (CPN) reviewed the man's mental health on 15 April and referred him to the doctor. A doctor saw him on 19 April and diagnosed 'acute stress reaction.' but did not prescribe any medication. He recorded that the man had had no further suicidal thoughts and regretted his acts.

38. On 6 May, the national population management unit advised Risley that as the man had failed in open conditions, he would be transferred to his originating establishment, The Mount, on 14 May. Both prisons were informed by email of the impending transfer details. There is no record that the man had been told that that his stay at Risley was a short-term arrangement and that he would be going back to The Mount. There is no evidence of any consideration being given to him remaining at Risley, where he appears to have settled and was closer to his family. His personal officer had spent some time with him while he was being constantly supervised in the segregation unit. On 9 May, she told the man that as he was desperate to work, she had arranged full-time employment for him to begin the next day. She said he looked happy and settled about this. He began his job the next day. He does not appear to have been told about his move until the morning of 14 May.

39. On 14 May, the man was taken to reception to complete the administration for his transfer to The Mount. As part of this process, a security department discharge check list is completed to ensure the correct documents accompany the prisoner. This includes a section to confirm that officers have checked wing files for any ACCT documents closed within the previous 30 days. As the man's ACCT had been closed on 12 April, this was marked as not applicable. Other documents to be included with his transfer were his core records, medical record and security file. It is also a requirement that a prisoner is declared fit for transfer by a member of healthcare staff.

40. The personal escort record (PER) is a mandatory document that accompanies a prisoner on all journeys to and from prisons. It is a communication tool to indicate a prisoner's risks and also serves as a chronological record of the journey. An administrative officer completed the man's PER form and indicated he had a history of self-harm but no other details were recorded. She explained to the investigator that after the PER was completed, it was the responsibility of offender categorisation and allocation department to attach any relevant documents. The PER should also be endorsed by a member of healthcare staff to identify any medical or mental health risks.

41. A nurse was responsible for completing the section on health risks. She had twice previously reviewed the man during his time at Risley - during his reception health screen when he was being constantly supervised as a high risk of suicide and on 7 April, when he was refusing to take food. Despite this previous knowledge, she did not identify or note any mental health risks or trigger factors and only partially completed his PER form. A tick box indicated there were no physical health concerns but the section on mental health was left blank and no information was recorded about previous ACCT monitoring, threats of suicide or triggers that could affect his mental health.

Transfer to The Mount

42. The man left Risley at 11.00am on 14 May and arrived at The Mount at 2.10pm. At reception, his transfer documents were handed to an officer who carried out reception checks. The electronic prisoner database, P-NOMIS, indicated that the man's incentives and earned privileges (IEP) status was standard, which limited his entitlement to the items of personal property which he had brought with him. When informed of this in reception, he became agitated and refused to co operate with the reception process or undergo a full health screen. He insisted he was an enhanced status prisoner and therefore should be allowed to have his own clothing and bedding. Staff at The Mount did not make any checks with Risley to confirm this.

43. A nurse had seen the man waiting for an initial health screen in reception and said he was calm at that time. After he had finished screening other prisoners, he went to get the man but a reception officer told him that he was refusing to cooperate with the health screen.

44. The man refused to go to the induction wing and asked to be taken directly to the segregation unit. Two officers and a custodial manager spoke to the man for about 45 minutes and attempted to persuade him to move to a cell in the induction wing but he refused. He said that he had been moved north to be nearer his family but had now been moved south again and was fed up with being moved between different prisons. He did not understand why his enhanced status had been reduced as he had had no IEP reviews at either Kirkham or Risley. He was then formally ordered to go to the induction unit. When he refused he was charged with an offence under Prison Rules for refusing a lawful order and given a notice of report for adjudication (a prison disciplinary hearing).

45. Officers escorted the man directly to the segregation unit, where he was required to take off his clothes to be searched. He was not allowed to have his own clothes back and refused to get dressed in prison clothing. A custodial manager tried to persuade him to wear prison clothing but he continued to refuse and remained in his underwear and shoes. He was given a blanket to cover himself and placed in cell 22. An officer left an induction pack, prison clothing and bedding for him in his cell.

46. A nurse or doctor assesses all prisoners within two hours of their move to the segregation unit. They carry out an initial segregation health screen, to assess the prisoner's suitability to remain in the unit, using a health safety algorithm (flow chart). Segregation unit staff are expected to check prisoners every hour during the first night. On 14 May, an officer was responsible for completing all documents for prisoners in the segregation unit. She checked and completed the prisoner details section on the health flowchart and noted on the form that the last time he had been monitored under the ACCT arrangements was a month before, on 13 April. (In fact it had been closed on 12 April.)

47. A nurse was allocated to work in the segregation unit that day and went there at about 3.00pm. She had been informed there was a new prisoner but had been given no further information about him and did not check his electronic medical record to get some background about him. She saw him in his cell and described him as calm, engaged and that he maintained good eye contact. He responded to her questions with one word answers and said he was all right and had no medical problems. The nurse assessed that he was suitable to be held in the segregation unit and this was countersigned by the duty governor at 4.10pm.

48. The man remained in his cell and declined anything to eat or drink at the evening meal time at 5.00pm. He spoke to two prisoners who were in nearby cells. One said he had spoken to the man at around 5.15pm. The man told him that he had been transferred from Risley and that during reception he found out his IEP status had been reduced from enhanced. He said he had not been allowed his own clothing or bedding, so he had asked to be taken to the segregation unit. When the prisoner asked him what he intended to do, he said he would ask to return to the wing in the morning. At the end of their conversation, he said he was going back to bed as he was cold. The second

prisoner said that he sounded upset but neither he or the other prisoner felt there were any indications of suicidal thoughts during their conversations. They thought that he was just upset about not being allowed his own clothes and other property.

49. After the evening meal, at about 5.00pm, the segregation unit is put into patrol state, which means that all the cells remain locked and there is no movement of prisoners. One officer remains on duty in the unit. That evening, an officer was on duty. She recalled that she was particularly busy that evening with paperwork for adjudications and dealing with some disruptive prisoners. At about 6.45pm, she realised that she had not carried out the required hourly observations and that the roll check (count of prisoners) was late. She began the roll check, starting at cell 14 and worked her way through the unit, arriving at the man's cell at about 6.55pm.

Emergency response

50. The officer looked through the cell observation panel and saw the man at the back of the cell in the left hand corner by the window. His arms were by his sides, his legs folded underneath him and he had what appeared to be a black cord around his neck. The officer called out to him and banged the cell door but he did not respond. She radioed for staff assistance at 6.56 pm but did not use an emergency code. She waited outside the cell for other officers to arrive. A general alarm bell was sounded and then a radio announcement requested staff assistance in the segregation unit.

51. An officer responded immediately as he was nearby and saw his colleague on the landing outside cell 22. He unlocked the door and they both went into the cell and saw the man sitting on the floor, slumped forward on the cell pipes, with a black shoelace around his neck. The officer cut the lace from around his neck. It was unclear where it had been attached to as the lace had broken. He then requested an ambulance. Four officers arrived and the officers took turns to administer cardiopulmonary resuscitation (CPR).

52. An officer told the investigator that she thought a defibrillator might have been needed during the resuscitation attempts. She was aware that the prison had recently obtained some, although they had not been trained how to use them. The officers asked a colleague to find a defibrillator, but neither he nor any other staff in the vicinity knew where they were.

53. An operational support grade (OSG), was in the prison's communications room. In a written statement, he said that at approximately 6.56pm, he had received an urgent message from an officer for staff assistance. At 7.06pm, this was followed by a request from a further officer for an ambulance. He immediately telephoned for an emergency ambulance but was unable to convey the nature of the emergency. These timings were listed on the incident log, which indicated that the ambulance arrived at 7.20pm. The officer who responded to the emergency call thought that it took around two minutes for the ambulance to arrive. The investigator also obtained the ambulance service notes. These indicate the call was logged by ambulance

control at 6.57pm and that the paramedics arrived at the prison at 7.05pm and were with the man at 7.08pm.

54. The paramedics continued emergency treatment but the man was unresponsive and resuscitation attempts were stopped at 7.40pm and he was pronounced dead. At 9.25pm an out of hours doctor certified his death.

55. Some members of staff were reported to be extremely distressed and were offered immediate support. A debrief was held the next morning. Officers at Risley were also told of the man's death and offered support. Prisoners were offered support from Listeners and the Samaritans.

56. As the man's family live in Scotland, the prison asked the police to inform them of his death, which they did that evening. A prison family liaison officer was appointed and contacted the man's family to offer support. The prison offered financial assistance towards funeral expenses. The man's property was returned to his family.

ISSUES

Clinical care

57. The clinical reviewer looked particularly at the mental health care the man received. She makes a number of recommendations in her review and we repeat in this report those most relevant to his death. She found that he had been referred to the mental health team at Kirkham and appeared to engage well with them. His care had been coordinated by a member of the secondary care team under the care programme approach, which aims to ensure consistent and synchronised care and this was equivalent to what would have been expected in the community.

58. The clinical reviewer notes that the man's transfer from Kirkham to Risley was well handled. Appropriate documents were sent, with detailed information about his previous ACCTs and a comprehensive mental health handover to staff at Risley. This mental health care continued at Risley but stopped once the ACCT was closed after which there was no further recorded mental health input. The clinical reviewer considers there was no rationale for stopping mental health support after the ACCT was closed. This is a concern as he moved so quickly from being constantly supervised to having no additional support. We make the following recommendation:

    The Head of Healthcare at Risley should ensure that prisoners with identified mental health problems continue to receive mental health support after an ACCT has been closed.

59. The man's transfer from Risley to The Mount was unexpected. This, together with issues such as his reduced access to IEP privileges, a transfer further away from his family and his preferred place of release, should have been viewed as possible triggers for additional acts of self-harm. She comments, 'All of his recent threats to self-harm/take his own life had been in reaction to how he felt about his continued sentence'.

Transfer to The Mount

Move from Risley

60. The investigator was told that the North West prison population is strategically managed and regulated by the movement of prisoners in and out of establishments within its region. The policy dictates that any lifer or IPP prisoner who is deemed unsuitable or fails category D conditions is returned to the originating establishment and that there were no exceptions to this. Therefore when the man was moved from Kirkham to Risley the national population management unit was contacted and asked to arrange a move back from Risley to The Mount. This was because he had been a prisoner at The Mount when it was first decided he was suitable for open conditions over a year earlier.

61. We are concerned that the rigid application of this population policy took no account of the man's individual needs. He had left The Mount more than a year earlier in February 2012 and had no particular ties with the area. After his transfer to Kirklevington and then to Kirkham he had re-established contact with his family in Scotland and made it clear that he wanted to remain in a prison in the north where he was closer to his family. He had only just settled on the induction wing at Risley after a period of constant supervision in the segregation unit when he had been regarded as a very high risk of suicide. He also had well documented mental health problems. None of these issues were considered as apart of a holistic assessment of what was best for his sentence progression and eventual resettlement when he was transferred from Risley to The Mount. A transfer back to closed conditions is distressing for any indeterminate sentenced prisoner and a time of heightened risk of suicide and self-harm. A move back to The Mount must have seemed an even further regressive move for the man at that stage of his sentence. We make the following recommendation:

The Deputy Director of Custody for the North West should ensure that moves of indeterminate prisoners take into account the individual needs of the prisoner and are based on clear sentence plan goals which reflect resettlement needs and the safety of the prisoner.

Communicating risks

62. Prison Service Order (PSO) 1025, *Communicating Information About Risks on Escort or Transfer*, sets out mandatory instructions regarding completion of the Person Escort Record (PER). The aim is to ensure that escort staff and receiving agencies are given information, particularly relating to a prisoner's risk and vulnerabilities and that "all relevant information regarding risk is commented on fully within the document". The prison is required to complete all sections of the form and provide supporting evidence about identified risks. When the prisoner arrives at the destination, reception staff should request the form and alert appropriate staff to any risks identified.

63. A nurse was responsible for recording information in the health risks section of the PER form on the morning of the man's transfer. She did not identify or note any mental health risks or triggers and the section on mental health was left blank. During interview, she seemed unsure of the process and responsibilities. She explained that on 14 May she was responsible for taking to reception sealed medical records which were prepared by the nurse on duty the night before and then endorsing the PER form that the prisoner was fit for transfer. She said that nurses would not necessarily see the prisoners before completing the form and, if there were any additional concerns about the prisoner's fitness for transfer, healthcare staff expected officers in reception officers to alert them.

64. We are concerned that the responsibility for ensuring that the PER form is completed accurately by healthcare staff is unclear and does not appear to allow an accurate assessment of any health concerns about a prisoner. The reception nurse does not check a prisoner's medical record before completing

and signing the form, so it seems to be a 'tick box' exercise rather than an accurate and valid assessment and does not help alert receiving prisons of any potential immediate heath issues. It is a concern that nurses are expected to endorse a prisoner as fit for transfer without the benefit of any prior knowledge or information. There is no evidence that anyone at Risley spoke to the man and considered whether a transfer back to The Mount had exacerbated his risk or whether an ACCT needed to be open, although the consequences for his sentence progression and future release were likely to be regressive. We make the following recommendations:

The Governor and the Head of Healthcare at Risley should ensure that prisoners are assessed in person for any health issues and risk of suicide and self-harm before any perceived adverse or unwelcome move and before assessing the prisoner as fit for transfer.

The Governor and the Head of Healthcare at Risley should ensure that the PER form is completed accurately with all mental health issues, risks or triggers for self-harm recorded to alert the receiving prison of any concerns.

65. Risley did not send information to The Mount with the man about his risks, apparently because his ACCT document had not been closed within the previous 30 days in line with the discharge check list. Prison Service Instruction (PSI) 64/2011, relating to the management of prisoners at risk of self-harm states that:

> "The safety and wellbeing of prisoners requires that any existing support and care is maintained in their new environment. This includes prisoners transferring between prisons…Prisons must ensure that all documentation travels with the prisoner, specifically any open or recently closed ACCT documents."

66. The man's ACCT document had been closed 31 days before his transfer to The Mount. In the light of his history, potential triggers of his self-harm and the reasons for his transfer, it would have been prudent to include it with his core records or at least flag up the risk. This is particularly so in this man's case as his risk had been regarded as so high when he was first moved from Kirkham, just a short time before, that he was subject to constant supervision – the highest level of ACCT monitoring possible. The clinical reviewer notes:

> "The lack of clear information and clinical handover upon transfer from HMP Risley and consideration of all the facts surrounding his history on initial assessment at the Mount placed him at significant risk. The possibility of significant self-harm and attempted suicide was foreseeable. The initiation of an ACCT at the point of transfer would have afforded him the most appropriate care at this time."

67. Although the ACCT document was not available, the dates of opening and closure had been recorded on his electronic records, which were available to all reception and healthcare staff at The Mount. We cannot say if access to

the ACCT document and greater knowledge of his risks would have prevented the man's death but it is important that all staff at the receiving prison have access to documented information of potential risks and triggers.

The Governor of HMP Risley should ensure that all relevant documents about risk transfer with the prisoner including ACCT documents closed outside a 30 day period when they contain important relevant information about the risk and triggers for suicide and self-harm.

Reception procedures at HMP The Mount

Initial health assessment

68. PSO 3050 *Continuity of Healthcare for Prisoners,* gives guidance on the clinical management of prisoners from reception to discharge. It is a mandatory requirement for prisons to carry out an initial assessment of the healthcare needs of all newly-received prisoners within 24 hours of first reception, to identify any existing health conditions and plan relevant care. A nurse expected to carry out the man's assessment but was told that he had refused to co operate with the reception process. He therefore did not receive a full reception health screening. He was immediately taken to the segregation unit, where a member of healthcare assessed his suitability to remain there.

Assessment of risk

70. PSI 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody) and PSI 74/2011, Early Days in Custody both list a number of risk factors and triggers for suicide and self-harm. These include, transfers between prisons, early days in custody, irrational behaviour, mental health problems, segregation, change in status and a history of self-harm. PSI 74/2011 also states that all staff should be alert to the increased risk of suicide/self-harm posed by prisoners in those categories and act appropriately to address any concerns.

71. It is a mandatory requirement that the PER and other available documents are examined and the prisoner is interviewed in reception to assess the risk of self-harm. The man's history of self-harm had been recorded on his PER as a risk, but staff do not appear to have actively considered this. In addition to the risk factors outlined above, the Parole Board had deferred a decision on his release a very significant risk factor for an indeterminate sentenced prisoner past his tariff date. He had a number of factors that were significant indicators of risk but these were not collated or assessed as he did not have an initial health screen.

The Governor of The Mount should ensure that that reception staff check and record all relevant documents including the PER and that all the known risk factors of a newly-arrived prisoner are fully considered and documented when determining his risk of suicide or self-harm.

Incentives and Earned Privileges status

72. At Kirkham, the man was an 'enhanced' prisoner and had access to additional items of personal property, including clothing and bedding. He retained this when he transferred to Risley. However, when he arrived at The Mount reception staff told him that his status recorded on P-NOMIS (the electronic records) was 'standard' and he would not be allowed to keep clothing and property he had previously been allowed. This appears to have been a major concern for him and he became agitated and angry. It prompted his refusal to co operate with the reception process and his request to be moved directly to the segregation unit.

73. When a prisoner transfers to another establishment, the P-NOMIS system automatically defaults their IEP status to standard and is therefore not necessarily accurate. Staff at The Mount attempted to pacify the man and explained that his IEP status would be explored within a few days. Despite his protests, reception staff at The Mount made no effort at the time to confirm his status by telephoning Risley. The Mount's IEP Policy states:

> "New receptions will enter as 'standard' regime. If the prisoner is claiming 'enhanced' status P/Nomis data should confirm this. However telephone/documentary evidence/contact with the previous establishment may be needed."

74. Reception areas are sometimes busy when a number of prisoners are transferred in at once. On this occasion, there were only two other prisoners, but no consideration seems to have been given to checking the man's determined claims that he had enhanced status. While his reaction seems to have been extreme, this should in itself have prompted some concern and a quick telephone call to Risley ought to have been able to resolve the issue. Instead, staff and managers expended considerable time and effort in segregating him rather than making a simple check. The staff at The Mount seemed to be unaware that prisoners' electronic records default to 'standard' on transfer and we note that an Inspectorate recommendation from an inspection in October 2011 that prisoners who had enhanced status at their previous establishment should retain that status on arrival at The Mount does not appear to have been implemented. We make the following recommendation:

The Governor of The Mount should ensure that reception staff carry out additional checks when a transferred prisoner queries his recorded IEP status.

Segregation

Initial segregation health screen

75. Healthcare staff should conduct a prisoner's initial segregation health screen within two hours of arrival in the segregation unit. This is not a full medical/mental health screening such as those carried out on arrival or in the

first few days of custody. It is in the form of a standard health safety algorithm (flow chart) which assists staff to assess the suitability of a prisoner to be located in the unit. There are only two possible outcomes. The first is that there is 'no health care intervention at this time' and the second is 'There are healthcare reasons not to segregate at this time,' 'discuss with health team'. This form is then endorsed by the person who carried out the screening and countersigned by the duty governor.

76. A nurse was notified at about 3.00pm that a prisoner was being taken to the segregation unit but she was given no further details or information about him. The health safety algorithm form was partially completed by an officer, who had identified and noted that he had been subject to ACCT monitoring in April 2013.

77. A nurse did not conduct any checks before completing the screening and had no knowledge of the man's medical or ACCT history. She described him as calm and engaged in their conversation but also said that he only provided one word answers to her questions. The completed form provided little information on the content of the screening or how she had reached her decision, so it appears that she relied solely on his presentation. Without the benefit of the man's previous history, it is difficult to understand how the nurse was able to assess his suitability for detention in the segregation unit. This was a further missed opportunity to assess whether he was at increased risk of suicide and self-harm.

78. The man's behaviour during the reception process reflected that of his previous transfer from Kirkham to Risley. However, these triggers for possible further acts of self-harm were not recognised by members of staff at The Mount who had not been alerted to or considered all the available information.

The Governor and Head of Healthcare at The Mount should ensure that all prisoners spending their first night at the prison in the segregation unit receive a comprehensive first night assessment of their physical and mental health based on their medical records and all other available information including the risk of self-harm.

Observation checks in the segregation unit

79. The Mount's policy is that all prisoners in the segregation unit are subject to hourly observation checks during their first night. These checks are noted and recorded on a wing log. The man arrived in the segregation unit at about 3.00pm and his last recorded hourly observation check was carried out at 5.00pm.

80. An officer explained she was the only officer on duty in the segregation unit, during patrol state and was very busy with paperwork and dealing with some disruptive prisoners in the unit. Just after 6.45pm she realised she had not conducted the 6.00pm hourly observation check and that the evening roll check was overdue. She immediately began the roll check and found the man at about 6.55 pm.

81. The man had not been checked for nearly two hours. We do not know whether an earlier check would have changed the outcome but prisoners in segregation units are often vulnerable, so it is important that they are monitored closely and at an appropriate frequency. As with ACCT checks such observations are more useful if they do not take place at predictable intervals. We make the following recommendation.

The Governor of The Mount should ensure that staff complete and record observation checks on all prisoners during their first night in the segregation unit at least once an hour at unpredictable intervals.

Emergency response

82. Prison Service Instruction (PSI) 24/2011 about management and security of nights states that where there is, or appears to be, immediate danger to life then cells may be unlocked without the authority of the night orderly officer. While we understand that officers must remain safe and assess immediate risks, they also have a duty of care to preserve life.

83. An officer discovered the man unconscious and unresponsive with a ligature around his neck. However, she remained outside the cell, radioed a general assistance call and waited for other staff to arrive. She did not use an emergency code so prison staff who responded were not aware of the nature of the incident or that emergency equipment was required.

84. An officer was immediately outside the segregation unit when he heard the assistance call so there was no real delay in opening the cell. The control was alerted before the officers went into the cell in line with PSI 24/2011. In situations such as this where a prisoner is unresponsive a quick response is vital in increasing the chances of successful resuscitation. Although there was no delay in this case and staff need to be satisfied of their safety in such situations, we note that the officer did not consider going into the cell alone.

85. PSI 03/2013 *Medical Emergency Response Codes* contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, procedures when there are no healthcare staff at night, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.

86. The Mount issued a local instruction on 4 April 2013. Although healthcare staff are not on duty at night, it does not explicitly outline the actions officers should take, such as collecting and using emergency equipment. It states that staff with concerns are permitted to request an emergency ambulance without waiting for healthcare staff but it does not make clear that an ambulance should be called automatically when an emergency code is called. The officer who first found the man did not use an emergency code, therefore staff who responded to the general alarm were not aware of the nature of the incident.

Use of a code should automatically trigger an ambulance being called but we are satisfied the custodial manager requested an ambulance quickly. While there is a conflict between the timings recorded for calling the ambulance and their arrival, the Ambulance Service records indicates that the ambulance arrived only a few minutes after he was found so on this occasion there was no delay.

87. The officers administered CPR without any emergency medical equipment. An officer was sent to get a defibrillator but no one on duty seemed to know where they were kept and none of the staff were trained in their use. It is apparent from the response to this emergency incident that there was a lack of clarity about what should happen in a medical emergency and that the guidance issued is insufficient and does not comply fully with the national instruction. There is evidently a need for The Mount to tighten up and practice its emergency procedures. We make the following recommendation:

The Governor of The Mount should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies including that, subject to a personal risk assessment, they should enter a cell in life-threatening situation, that there are sufficient trained staff to administer basic life support and that The Mount 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.**

RECOMMENDATIONS

Deputy Director of Custody – North West

1. The Deputy Director of Custody for the North West should ensure that moves of indeterminate prisoners take into account the individual needs of the prisoner and are based on clear sentence plan goals which reflect resettlement needs and the safety of the prisoner.

HMP Risley

2. The Head of Healthcare at Risley should ensure that prisoners with identified mental health problems continue to receive mental health support after an ACCT has been closed.

3. The Governor and the Head of Healthcare at Risley should ensure that prisoners are assessed in person for any health issues and risk of suicide and self-harm before any perceived adverse or unwelcome move and before assessing the prisoner as fit for transfer.

4. The Governor and the Head of Healthcare at Risley should ensure that the PER form is completed accurately with all mental health issues, risks or triggers for self-harm recorded to alert the receiving prison of any concerns.

5. The Governor of HMP Risley should ensure that all relevant documents about risk transfer with the prisoner including ACCT documents closed outside a 30 day period when they contain important relevant information about the risk and triggers for suicide and self-harm.

HMP The Mount

6. The Governor of The Mount should ensure that that reception staff check and record all relevant documents including the PER and that all the known risk factors of a newly-arrived prisoner are fully considered and documented when determining his risk of suicide or self-harm.

7. The Governor of The Mount should ensure that reception staff carry out additional checks when a transferred prisoner queries his recorded IEP status.

8. The Governor and Head of Healthcare at The Mount should ensure that all prisoners spending their first night at the prison in the segregation unit receive a comprehensive first night assessment of their physical and mental health based on their medical records and all other available information including the risk of self-harm.

9. The Governor of The Mount should ensure that staff complete and record observation checks on all prisoners during their first night in the segregation unit at least once an hour at unpredictable intervals.

10. The Governor of The Mount should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies including that subject to a personal risk assessment, they should enter a cell in life-threatening situation, that there are sufficient trained staff to administer basic life support and that The Mount 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.

ACTION PLAN: **[man's name] – HMP The Mount, HMP Risley and DDC North West – 14 May 2013**

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	**Deputy Director of Custody – North West** The Deputy Director of Custody for the North West should ensure that moves of indeterminate prisoners take into account the individual needs of the prisoner and are based on clear sentence plan goals which reflect resettlement needs and the safety of the prisoner.	No response	As described above (Pg 17, Para 60 & 61) we believe this is the result of a misinterpretation of events. The parole report, release plans and NOMIS case notes clearly evidence that 'the man's' needs were taken into account in the decision to move him to The Mount, which was a progressive move and in line with national policy.	N/A	
2	**HMP Risley** The Head of Healthcare at Risley should ensure that prisoners with identified mental health problems continue to receive mental health support after an ACCT has been closed.	Accepted	The Mental Health Team at Risley continues input with patients with a mental Health condition once an ACCT is closed. However some patients may decline this input. The Mental Health Team maintain contact if a person is on their caseload and also if a person develops a mental illness whilst on an ACCT the case will be allocated and the Mental Health Team will maintain input.	July 2014	
3	The Governor and the Head of Healthcare at Risley should ensure that prisoners are assessed in person for any health issues and risk of suicide and self-harm before any perceived adverse or unwelcome move and before assessing the prisoner as	Accepted	Where there is any perceived adverse or unwelcome transfer staff will ensure that recent case notes are reviewed and recent triggers noted. If there any concerns highlighted or raised the nurse will arrange for the patient to be seen prior to transfer.	July 2014	

	fit for transfer.		Where there is risk of Self Harm highlighted an ACCT document will be opened and the receiving establishment contacted to discuss the move. Any prisoner on an open ACCT will be reviewed on the day of transfer and the receiving establishment informed of the outcome of this review. Safer Custody Team will be informed and ensure that the receiving establishment is aware of the risks.		
4	The Governor and the Head of Healthcare at Risley should ensure that the PER form is completed accurately with all mental health issues, risks or triggers for self-harm recorded to alert the receiving prison of any concerns.	Accepted	All nursing staff who complete PER forms to be instructed to review case notes prior to completing PER forms and any issues to be raised with senior Nurse and if appropriate escalated to Oscar 1. Process to be monitored.	July 2014	
5	The Governor of HMP Risley should ensure that all relevant documents about risk transfer with the prisoner including ACCT documents closed outside a 30 day period when they contain important relevant information about the risk and triggers for suicide and self-harm.	Accepted	Safer Custody department now routinely monitor all transfers out of the establishment. We then complete an Annex Q which details self harm history and forward this to the receiving establishment. As part of the process we keep copies of what we send and delivery receipts.	Completed	

6	**HMP The Mount** The Governor of The Mount should ensure that that reception staff check and record all relevant documents including the PER and that all the known risk factors of a newly-arrived prisoner are fully considered and documented when determining his risk of suicide or self-harm	Accepted	The Reception Procedures Protocol and Job Descriptions will be updated and republished to remind staff of the importance of adhering to these requirements. Current staff will be briefed and new staff will be informed as part of their induction.	30 April 2014	
7	The Governor of The Mount should ensure that reception staff carry out additional checks when a transferred prisoner queries his recorded IEP status.	Accepted	The IEP level on NOMIS should have been checked and returned to 'Enhanced' when 'the man' was transferred to Risley from Kirkham. If this had been done there would have been no issue for staff at The Mount, who would have been aware of 'the man's' Enhanced status. This point will be addressed by the Governor of Risley. The Governor of The Mount will ensure that further clarification is sought if a future similar case arises by instructing staff to contact the sending establishment directly to clarify the IEP level.		
8	The Governor and Head of Healthcare at The Mount should ensure that all prisoners spending their first night at the prison in the segregation unit receive a comprehensive first night assessment of their physical and mental health based on their medical records and all other available information including the risk of self-harm.	Accepted	A notice to staff will be issued to reiterate that a comprehensive assessment of prisoner's physical and mental health will be completed if it is the first night in prison. This will be cascaded to the SMT and all staff via staff briefings.	July 2014	

9	The Governor of The Mount should ensure that staff complete and record observation checks on all prisoners during their first night in the segregation unit at least once an hour at unpredictable intervals.	Accepted	The Daily Diary in the CSU currently records regular hourly observations. The diary will be amended to encourage and demonstrate irregular observations. Safer Custody awareness training will be delivered to all CSU staff paying particular attention to those prisoners who are located on their first night in the segregation unit.	April 30 2013	
10	The Governor of The Mount should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies including that subject to a personal risk assessment, they should enter a cell in life-threatening situation, that there are sufficient trained staff to administer basic life support and that The Mount has a Medical Emergency Response Code protocol which: a) Provides guidance to staff on efficiently communicating the nature of a medical emergency; b) Ensures staff called to the	Accepted	A staff training package regarding PSI 03/2013 and specifically covering Medical Reponses will be created and delivered to operational staff. Cards will be created on the back of all staff IDs that show the different emergency response codes as an aide memoir. The Establishment already ensures that we have adequate numbers of first aid trained staff. There is a medical response code in place for this (codes red and blue). There is also	Sept 30 2014 Completed Completed	

	scene bring the relevant equipment; and c) Ensures there are no delays in calling, directing or discharging ambulances		information on the Z drive for staff on how to recognise an emergency. An Information staff notice went out for this last year and can be reissued. This is in place. Unfortunately there are issues regarding the response times from the Ambulance service in emergencies which has been reported to the Commissioners in NHS England, East Anglia Branch	Ongoing	