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 while a prisoner at HMP Forest Bank in November 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 died in November 2013 after being found hanging in his cell at HMP Forest Bank the previous day. The man was 26 years old. I offer my condolences to his family.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care that the man received in prison. The prison cooperated fully with the investigation.

The man took an overdose of medication on 10 October 2013 for which he received treatment at hospital. On 15 October, he was sentenced to 19 weeks in prison for harassment and a restraining order was imposed preventing him from contacting his wife or children. A court mental health worker contacted the mental health team at HMP Forest Bank to alert them that the man would arrive later that day and to indicate her concerns that he was at risk of suicide. Despite the warning and evident risk factors, staff at Forest Bank did not consider that he needed suicide and self-harm monitoring when he arrived at the prison.

Over the course of the next three weeks, the man made several comments to staff that he would kill himself before he completed his sentence, but no one began monitoring him as a risk of suicide.

I am very concerned that reception staff and then others at the prison did not properly consider the man’s risk. This meant that they failed to open suicide and self-harm monitoring, leaving the man without the support he needed. Indeed, it is difficult to understand how so many known risk factors could be ignored. For example, staff appear to have discounted a suicide warning from the court and then appear to have ignored the fact it was his first time in prison, he was suffering from depression, he had recently attempted to kill himself, he had relationship difficulties and had been convicted of violent offences against a family member. All of these are known risk factors which should have alerted staff. These were fundamental errors that were repeated throughout the man’s short stay at Forest Bank. The Director needs to ensure that all the staff have a better understanding of risk factors for suicide and when monitoring is necessary.

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 **May 2014**

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SUMMARY

1. In January 2013, the man was convicted of assault against his wife and given a six week suspended prison sentence. On 11 October, he went to hospital after taking an overdose of medication. On 15 October, he pleaded guilty to charges of harassment against his wife. Court staff completed a suicide and self-harm warning form. Separately, a mental health worker at court telephoned HMP Forest Bank, where the man was taken, to alert them to her concerns about his risk.

2. A senior officer, a healthcare assistant and a mental health nurse saw the man in the prison's reception when he arrived. Despite the information they had about him, none of the staff began suicide or self-harm monitoring.

3. The man spent three days in the healthcare unit to be monitored for an internal bleed resulting from his overdose. Three different GPs saw him, and at each consultation he indicated that he would harm himself. None of the GPs began self-harm monitoring.

4. There were a number of other indications during the man's time at Forest Bank that he might harm himself. On 4 November, an officer was concerned about him and asked someone from the mental health team to see him. This did not happen before he died. That evening, the man telephoned his mother and said he could not cope in prison. He asked her to look after his children. The call was monitored and a wing officer spoke to the man the next morning. The man told the officer that he had no thoughts of suicide or self-harm.

5. On the afternoon of 5 November, an officer was completing a roll check when he found the man hanging in his cell. Officers, healthcare staff and paramedics managed to establish a pulse and the man was taken to hospital. Sadly, he did not recover and died on 6 November.

6. We are concerned that none of the staff who encountered the man identified that he was at risk of suicide. A suicide and self-harm warning form from court clearly set out that the man had recently tried to take his own life and a mental health worker from the court had telephoned the prison to say she was concerned about him. Despite this, no one began suicide and self-harm monitoring and the staff failed to take into account a range of risk factors. Instead they based their initial assessments on his presentation. We have identified several further occasions when suicide and self-harm monitoring should have begun. We make recommendations about the suicide and self-harm monitoring process at Forest Bank.

7. There is also a need for a clearer process for mental health referrals and we are concerned that there was no adequate plan to treat the man's internal bleeding. While this did not contribute directly to his death, the lack of treatment clearly affected his frame of mind.

THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners at HMP Forest Bank about the investigation. No one contacted the investigator, as a result.

9. The investigator visited Forest Bank on 12 November. He collected copies of the man's clinical and prison records and visited the houseblock where he had lived. He spoke to the Director of Forest Bank and a member of the Independent Monitoring Board.

10. The Clinical Reviewer reviewed the man's clinical care. Her review is annexed to this report.

11. The investigator and Clinical Reviewer interviewed 22 members of staff at Forest Bank in December 2013 and January 2014. The investigator gave verbal feedback to the Director, which he followed up in writing.

12. The investigator spoke to the local Coroner and kept her informed of the progress of the investigation. We have sent a copy of this report to the Coroner.

13. Our family liaison officer contacted the man's brother to discuss the investigation. The man's brother said that the prison had offered to assist with funeral expenses and had returned the man's property. The man's brother said that he did not have any immediate concerns to raise.

14. The man's family received a copy of the draft report as part of the consultation period. They provided comprehensive written representations in response to the findings of the investigation and an impact statement, which has been forwarded to the coroner. The man's family welcomed the recommendations in the report. Although the feedback has not led to any changes to the investigation report, we have sought to provide further information where appropriate to some of the points raised by way of separate correspondence to the man's family.

HMP FOREST BANK

15. Forest Bank is a local prison in Salford, serving courts in the North West. It holds around 1,364 remanded and sentenced men. The prison is privately managed by Sodexo Justice Services. Primary health care services are provided by Sodexo. There is a 20-bed inpatient unit with 24 hour nursing cover. An agency provides GP services with doctors available from 9.00am to 9.00pm Monday to Friday, 1.00pm to 5.00pm Saturday and 9.00am to 12.00pm Sunday. There is out of hours cover at other times.

Her Majesty's Inspectorate of Prisons

16. HM Inspectorate of Prisons (HMIP) most recently inspected Forest Bank in 2012. Inspectors found that reception processes were appropriate, and that first night arrangements were good. The suicide and self-harm policy was well-publicised. Inspectors found that a quarter of prisoners being monitored under suicide and self-harm procedures were housed in the healthcare unit. .

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In their latest annual report for 2012-13, the IMB noted that staff had a good understanding of the suicide and self-harm monitoring process, and that induction ensured that prisoners knew about support services.

Previous deaths at Forest Bank

18. The previous self-inflicted death at Forest Bank was in January 2010. Since then, there have been nine deaths as a result of natural causes. Following an investigation into a death from natural causes in 2011, we made a recommendation that prisoners who expressed thought of self-harm to either medical or prison staff should be managed under the ACCT process (see below). The prison accepted this recommendation and told us that all medical and prison staff had undertaken ACCT foundation training.

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 the 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 not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and 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 the actions of the caremap have been completed.

KEY EVENTS

20. In January 2013, the man was convicted of assaulting his wife. He was given a six week prison sentence, which was suspended for 12 months.

21. In early October 2013, the man telephoned his wife several times and sent various text messages including photographs suggesting he intended suicide. On 10 October, he took an overdose of various medications and alcohol and, the next day, was admitted to Fairfield General Hospital. He was discharged that evening, but returned to the hospital on 12 October complaining that he was bleeding from his gastrointestinal (GI) tract, and had black stools. He was given medication and told to see his GP.

22. On 14 October, the man was arrested. He appeared at Bury Magistrates' Court on 15 October and pleaded guilty to charges of harassing his wife over the previous week. The charges referred to "images which intimated suicide". He was sentenced to 19 weeks in prison (three weeks of this sentence was from the previous suspended sentence) and was made subject to a restraining order banning him from contacting his wife or children for two years. (His sentence was due to expire on 24 February 2014, although he would have been eligible for unconditional release on 20 December 2013 and for home detention curfew on 18 November 2013.

23. While he was at court, staff began monitoring the man after noticing that he had superficial cuts to his arms. He was described as not being very responsive and was volatile. The staff completed a suicide/self-harm warning form. This noted that the man had a history of depression and was low in mood because he was in custody.

24. At 11.20am, a criminal justice mental health practitioner at Bury Magistrates' Court, saw the man with a colleague. He was observed at regular periods throughout the day before being taken into court for sentencing at 4.27pm. On the Person Escort Record (PER, a form which provides a record of events while a person is in custody), staff noted that they had to use force to remove the man from the dock. They also noted that the man had self-harm marks to his wrist and neck but did not indicate that the man had recently taken an overdose.

25. After the man was sentenced, the mental health practitioner telephoned Forest Bank and spoke to a member of the mental health inreach team to say she was concerned about the man. The mental health practitioner then faxed a Suicide Risk Form (SR1) to Forest Bank. On the form, she noted that the man had been displaying impulsive suicidal behaviours (including the overdose and threatening to jump from a bridge) and had threatened deliberate self-harm in response to his wife wanting to end their relationship. The mental health practitioner questioned whether the man had a personality disorder. She included the hospital discharge summaries in her fax.

26. After this conversation, a member of staff from the mental health inreach team spoke to a healthcare assistant to advise her that the man was likely to arrive

at Forest Bank later that evening. The healthcare assistant recorded that the man had a long history of domestic violence, but his wife had recently ended their relationship, causing him to self-harm. The healthcare assistant also noted that the man had threatened to kill himself while at court. The healthcare assistant told the investigator that she had passed this information to the senior custody officer in reception.

27. The man arrived at Forest Bank and the senior custody officer saw him in reception. He recorded in the man's prison record that the man had arrived with a suicide and self-harm warning form, and had a history of depression and self-harm. He noted that the man had never been in prison before, and that all avenues of support had been explained to him. Finally, the senior custody officer noted that the man had seen a mental health nurse, who had not raised any concerns. In his record, the senior custody officer wrote that staff should monitor the man, but he did not open an ACCT.

28. When interviewed, the senior custody officer explained that reception staff only make a note in the prison record when there is information about a possible risk of self-harm. He said that he did not specifically recall the man. Although he was fully ACCT trained, and acts as a case manager, he said that he would usually defer to the experience of a mental health nurse to advise whether a prisoner needed to go on an ACCT. The senior custody officer said that he could only go on what the prisoner told him and his presentation if that was the only information he had. He said that he would expect a nurse to open an ACCT without necessarily referring to him if they thought that it was necessary.

29. At 7.11pm, the healthcare assistant saw the man for a reception health screen. The man told her that he had suffered a brain injury when a piece of metal went through his head when he was a child. He said that he had gone to hospital on 11 October, after cutting his wrist and taking an overdose. The overdose was now causing him to bleed from his rectum. He said that he had been due to return to the hospital that day for a gastroscopy (an internal examination of the stomach), although the discharge record suggests that he had been advised to see his GP. He also said that he had an appointment with a psychiatrist on 16 October. He said that he had not been taking his anti-depressant medication (sertraline) for the previous two weeks.

30. The healthcare assistant asked a nurse, from the mental health inreach team, to see the man. The healthcare assistant told the investigator that she had seen the nurse conduct the assessment with the man, but in a different room from her. There is no record of the nurse's assessment in the medical record, and the healthcare assistant said that she did not discuss the assessment with the nurse. The nurse told the investigator that she had conducted the assessment with a healthcare assistant present. (Neither of the healthcare assistants thought that they were present.) She said that, when she came to make a note of the assessment in the medical record, it would not save properly. (The Head of Healthcare at Forest Bank has since told us that she was not aware of any problems with the computer system.)

31. The nurse recalled that the man had told her that he had previously had support from mental health services, but now did not have any thoughts of self-harm. He told her that he was more concerned that he would not be able to tolerate prison food and could not eat hospital food. The nurse could not recall being told about the referral from the mental health practitioner and she did not remember what paperwork she read before seeing the man. The nurse said that, if she had information that a prisoner had a recent history of self-harm, she would usually open an ACCT.

32. A first night care plan assessment was completed. The man did not raise any concerns and said that he had no thoughts of suicide or self-harm. The officer who completed the form ticked that they did not have any immediate concerns about the man's welfare.

33. The next day, an officer and a wing auxiliary began the induction process and gave the man information about prison procedures and rules. When interviewed, neither could remember the man.

34. At 9.41am, a prison GP saw the man and noted that this was the man's first time in prison and that he was prescribed an antidepressant, but was not taking it. The man said that he felt depressed and suicidal after his overdose. He also mentioned that he had a gastrointestinal bleed. The GP noted that the man was quiet and calm, but did not talk much and wanted to be left alone. The GP recorded that he planned to review the man with the nurse.

35. The nurse told the investigator that she did not recall talking to the GP about the man, although the GP thought they had and that the nurse had said that the man was fine. The GP recalled that the man was quiet and that, if he had not known about his recent overdose, he would have thought that he was acting in the same way as he would expect for any other new arrival. The GP said that he was not ACCT trained, but that healthcare assistants were, and that they would often open ACCTs if necessary. He said that he had read the man's record and was aware of his medical and criminal history.

36. On the same day, 16 October, the man's induction continued. A senior officer reviewed the man's cell sharing risk assessment form (CSRA) which decides whether a prisoner is a risk of violence towards another prisoner). On the front of the form, the senior officer noted that the man had a history of self-harm and mental health issues. The senior officer told the investigator that she always noted such issues on the front of the CSRA because every officer used the information when risk assessing a prisoner. (Although this is not the purpose of the CSRA.)

37. That morning, the man's reception documents were passed to the administration team. As there was a suicide and self-harm warning form among the papers, the custody clerk advised both the safer custody team and the induction wing that the PER form included information about risk of suicide and self-harm. When interviewed, the custody clerk said that she always telephoned the wing with this information.

38. The safer custody team also noted this information and sent a notice to the wing advising them to be aware. On the notice to the wing, there was a clear instruction that an entry should be made about this information on PNOMIS. The notice also said that the wing senior officer had been informed by telephone.

39. When interviewed, the wing senior officer said that she did not recall that shift. She said that there are usually three people on duty and that anyone of them might have picked up the notice. She said that, had she received the notice, she would have gone to talk to the man. She said that her understanding of the notice was that a note should have been made on PNOMIS. She did not recall anyone from the safer custody team speaking to her about it.

40. On 18 October, the man saw a nurse because of his ongoing gastrointestinal bleed. She referred him to the GP, who noted that the man would not eat unless he made the food himself. (The nurse recorded that the man had a fear of eating in strange places.) The GP requested blood and stool tests, as well as other clinical observations. He admitted the man to the healthcare unit as an inpatient for monitoring.

41. The next day, a GP reviewed the man who said that he was continuing to refuse to eat as he would only eat food that he had prepared. It was also as a protest because he had not received any letters with contact telephone numbers. He said that he knew his wife's number, but was not allowed to call her. He wanted to know if he had anything else to live for, said that he felt that there was no point in him being there and thought his children were better off without him. He said that if he had not been able to have any contact with his family, or if he had bad news about his relationship, by the following Tuesday (22 October), he would "do something", although he refused to elaborate what he meant by this. The GP reviewed his gastrointestinal symptoms and encouraged him to take omeprazole (which is used to treat stomach complaints). She noted that if that did not help, a GP should refer the man for further examination. The man said that he would refuse to take any medication.

42. The GP told the investigator that the man was initially frustrated and agitated at the start of the consultation. She said that she was concerned about him and that she had asked him further questions about what had triggered his feelings about his family, and about why he thought that he was not a good father. She said that she tried to motivate him to value himself and see how things might improve. The GP told the investigator that she thought that the man was frustrated but not suicidal. She was concerned about his threats to do something if he did not have some contact with his family by the next Tuesday, so she had shared this information with nurses and recorded it in his medical record. Although she had not been ACCT trained, she said she had opened ACCTs for other prisoners when she was concerned they might be at risk.

43. On 20 October, the man remained in healthcare. He showed a stool sample to a nurse who noted that there was some evidence of melaena (black colour caused by blood).

44. The next day, 21 October, another GP noted that the man refused to see him. At 2.12pm, a nurse went to take his blood pressure and the man verbally abused her because he said she was, six hours late. The nurse noted that he was refusing to take his medication.

45. Shortly afterwards, the man agreed to see the GP. He said that he would not eat, drink or take medication because there was a court-imposed restraining order preventing him from contacting his wife and, as a result, he would starve himself to death. The GP noted that he reiterated the need for him to eat and drink, but the man walked out. The GP gave the man the results of his blood tests and explained that he had a low haemocrit (number of red blood cells) level. The GP did not think that keeping the man in the healthcare unit was achieving anything, and wrote that he should be transferred back to his "pad and monitored as he seems motivated to harm himself". The GP further wrote that if his safety could not be guaranteed on the wing, he should be transferred to a safe place (possibly the healthcare unit). The unit manager at the time agreed to this move. The man returned to E wing, the induction unit.

46. When interviewed, the GP told the investigator that he had not received ACCT training but had discussed putting prisoners on ACCT with reception staff. He said that he was concerned about the man's threat to starve himself to death but this was not uncommon for prisoners, who usually relented. He was not sure how the man's food intake would be monitored. The GP said that he was asked to assess whether the man needed to remain in the healthcare unit and, as he was refusing to eat, drink or take medication, The GP did not consider that his location made a difference. He said that he thought that someone would keep a regular watch on the man on the wing, although he could not explain how he thought this would be achieved. Although he had recorded that the man seemed motivated to harm himself, the GP told the investigator that he did not think that the man would do so.

47. That evening, an officer spoke to the man, and recorded the conversation in the man's prison record. The man said that he just wanted contact with his family and was waiting for their contact numbers to arrive. He said that he wanted to move to a houseblock and the officer told him that he would once a cell became available. He noted that the man was mixing better with others on the induction unit.

48. On 25 October, at 11.44pm, a healthcare assistant was called to see the man on the induction unit, as he was complaining of stomach pains. He asked for pain relief and told her that he had eaten two bags of crisps and had drunk ten glasses of water. The healthcare assistant said that she would speak to the night duty nurse, although he was unlikely to get any medication that night. She also offered to list him for triage the next day. She said that the man then became abusive and said that she should know his medical history and that

he had a gastrointestinal bleed. The man did not attend triage clinic the next day.

49. The man attended triage on 27 October, when he saw a nurse who recorded that the man was rude from the outset. He told her that he was not on hunger strike and was unwilling to tell her why he had attended for triage. The nurse eventually asked him to leave as she felt that they were going round in circles. The man was given a behaviour warning for being abusive to an officer as he left the healthcare unit.

50. On 30 October, two welfare officers went to see the man on the wing to discuss his accommodation plans when he left prison. The man told them that, if he did not get released on home detention curfew, the only way he would leave Forest Bank would be in a body bag. One of the welfare officers recorded in the man's prison record that he continuously said that he would kill himself. The welfare officer spoke to a senior custody officer, and discussed whether the man should be on an ACCT. The senior custody officer told the investigator that they had agreed that there was no need to open an ACCT. He said that he spoke to the man later who said that he was fine and did not have any problems with his family. The senior custody officer thought that the man was genuine.

51. A nurse saw the man again on 31 October, as he was complaining of abdominal pain and of a continuing gastrointestinal bleed. The nurse noted that there was no evidence that he was in pain as he was sitting comfortably when she arrived and stood for some time chatting before bending down to take off his shoes. He said that he should be sent to hospital, but the nurse advised him to increase his fluid intake as she thought that he was constipated. The man became argumentative and demanded to be sent to hospital. The nurse said that she did not have good reason to send him to hospital. She gave him containers for further urine and stool samples.

52. The man moved from the induction unit (E wing) to D2 wing on 2 November. D2 is a drug-free wing and prisoners there sign a behaviour compact. Prisoners there are usually regarded as well-behaved and quiet. An officer was on duty when the man arrived on the wing. She noticed that he looked ill and asked him what the problem was. He said that he had a bad stomach. The officer told the investigator that she spoke to him and played pool with him, but he did not say much, other than about his stomach problem.

53. On 4 November, the officer encouraged the man to go to the education department. He attended a health and safety class. However, she remained concerned about him and made a note in the man's electronic prison record that he was not well, was not eating prison food but was drinking. She noted that staff should monitor him. That morning, another officer telephoned the mental health inreach team about another prisoner. As she was on the telephone, the first officer asked her to refer the man. She told the investigator that she thought that the man could do with some help as he was very quiet, but that she had not been concerned that he would harm himself.

54. The officer told the investigator that she also called the healthcare unit and asked for a nurse to come and see the man about his stomach. She was told that they knew about the man, that he had been removed from the healthcare unit and that he was manipulative. There is no record of this conversation in the medical notes.

55. A member of the mental health inreach team took the call from the second officer. She noted that the man had been refusing to eat, but that also that he was banging in his cell and keeping others awake. As he had not been diagnosed with a serious and enduring mental illness, she referred him to the primary mental health team for triage. The member of the mental health inreach team told the investigator that she used SystmOne (the electronic medical record system) to send a task to the primary mental health team. That team did not see the man before he died. The nurse explained at interview that she did not see the task until the evening of 5 November. The man had not been assessed as a priority, so he would not have been seen immediately. She said that, as the referral had been made on Monday 4 November, he would have been seen, at the latest, by the Friday that week (8 November).

56. The man spoke to his mother on the telephone at 5.21pm on 4 November for 15 minutes. A security officer listened to the call as part of random monitoring later that night. During the call, the man said that he could not cope in prison, was not eating and that no one was doing anything about it. He asked his mother to look after his children. The security officer noted that the man sounded down and was concerned that he might harm himself.

57. Because of the concern, someone from the security department spoke to an officer the next morning and asked him to speak to the man. The officer noted in the man's prison record that he had seen the man at 8.07am. The man told him that he had no thoughts of harming himself, but that he was ill and was not being seen by healthcare. At interview, the officer said that the man told him that he was not feeling down, but that he had a problem with his stomach and did not feel that healthcare staff were taking him seriously. The officer said that the man gave good eye contact and seemed genuine in what he said, and that he did not have any concerns about him. He told the man that if he wanted to see a nurse he should put an application in the box. The man told him that he had already done so.

58. The officer told the investigator that he finished his shift at 12.15pm. He said that he did not recall seeing the man again that morning and was fairly certain that he did not go to the exercise yard that morning.

59. Officer A usually worked on C wing, but that afternoon he was detailed to work on D wing. He came on duty at 12.15pm. He told the investigator that there was a handover from the morning shift, but that the man was not mentioned. He said that he had not met the man before. Officer B was on duty with Officer A and had started his shift at 7.30am. He said that he did not know the man as he also did not usually work on D wing.

60. Officer A explained that shortly before 4.45pm, he and Officer B started a roll check after prisoners had returned to the wing from work. Officer A checked D1 landing, while Officer B checked D2 landing. Officer B said that he got to The man's cell (cell 44) and opened the flap on the observation panel. He found that the panel had been covered, so he decided to go in to the cell. He did not try and speak to the man first.

61. When he went in, Officer B thought that he saw the man standing urinating at the toilet, facing away from him. He told the man to clear the observation panel. As he began to leave the cell he realised that something was not right. He turned back and saw that the man was hanging from a ligature made from a bed sheet, which had been threaded around a bolt in the panel by the toilet.

62. Officer B then cut the ligature from the bolt. The ligature came away from the man's neck as Officer B lowered him to the floor. He said that he shouted to Officer A to lock some prisoners who were working in the wing servery back in their cells. Once he had placed the man on the floor, he called a code blue (an emergency code which signifies that a prisoner is unconscious or not breathing) using his radio. The control room logged this call at 4.43pm and immediately called an ambulance.

63. Officer B started cardiopulmonary resuscitation (CPR). He then thought that the man was looking at him and panicked and put him in the recovery position. He left the cell as the orderly officer arrived. The orderly officer checked the man and found that his eyes were fixed. He told Officer B to begin CPR again.

64. Two nurses arrived shortly after the orderly officer. The first nurse had collected the emergency red bag on the way, and the second nurse had brought a defibrillator. (A life-saving device which gives the heart an electric shock in some cases of cardiac arrest.) The first nurse checked the man's pupils but did not get a reaction. She inserted an airway and attached an oxygen mask. The second nurse attached the defibrillator but it did not advise a shock. They continued CPR. The GP had arrived and tried to insert a cannula into The man's arm so that drugs could be administered. However, he was unable to do so.

65. The ambulance arrived at the prison at 4.50pm. When the paramedics arrived at The man's cell, they managed to inert a cannula and administered some medication. They attached their own defibrillator, which recorded some activity in the heart. The paramedics administered several shocks and decided to take The man to hospital. The man was taken to the ambulance at 5.27pm. The ambulance left the prison at 5.38pm.

66. A chaplain at Forest Bank acted as the prison's family liaison officer and at 5.30pm contacted the man's brother, who was his named next of kin, to explain that the man had been taken to hospital. The chaplain and the duty governor went to Salford Royal Hospital and met the man's brother, mother and brother-in-law. They explained what had happened and the man's mother told them that he had made similar attempts before. After his family

had been to see the man, his mother told the chaplain that she had spoken to the man the previous day and that he had seemed fine. The chaplain and the duty governor left the hospital at 8.20pm,

67. The next day, the chaplain went to the hospital. He had been told by the prison's head of residence that the hospital was preparing to switch off life support machines. The chaplain was with the man's family when the machines were turned off at 9.20am and, with the agreement of his mother, said a prayer. After they left the room, the chaplain explained that the prison would contribute to the costs of the funeral and invited them to visit the prison. He called the man's mother later that day and helped facilitate the return of the man's property.

68. Two letters were found in the man's cell. One was written to prison staff and said:

> "(You failed) Prison staff
> I'm so sorry
> Please do not help
> (not that you have before. You treated me like shit, I didn't [deserve] it"

69. The second letter was addressed to the man's family. He said that he had gone to a better place and asked them not to hate him. He apologised for making their lives difficult.

70. A post-mortem examination was conducted on 7 November at the Royal Oldham Hospital. The pathologist found that the primary cause of death was hypoxic brain damage, which had occurred because of the cardio-respiratory arrest caused by hanging. The pathologist thought that the man could only have been hanging for a short period of time as he had been resuscitated. The pathologist also noted that the man had a gastric ulcer, which was bleeding, and mild gastric inflammation. She said that these would have explained the symptoms of which he was complaining while in prison. The pathologist also noted that the man was anaemic and attributed this to the ulcer. A toxicology test found no trace of alcohol or drugs.

ISSUES

Assessing the risk of suicide and self-harm

71. We believe that the reception officers and healthcare staff should have opened an ACCT document for The man. We consider that there were a number of further opportunities for staff to have considered opening an ACCT during The man's time at Forest Bank. A summary of these interactions is as follows:

    - In reception on 15 October, either by the reception officer the senior custody officer (who had the warning form from the court stating he was at risk of suicide) or by either the healthcare assistant or the nurse (who had been advised of the man's recent overdose and other suicidal acts by the mental health worker at court and who had the best access to information on which to open an ACCT).
    - On 16 October, when the man was in the induction unit and a reminder about his risk of suicide and self-harm was sent to the unit by both the custody clerk and the safer custody team.
    - On 18 October, when the man told the GP that he felt suicidal.
    - On 19 October, when another GP saw the man and he told her that he would "do something" if he did not have contact from his family within the next three days.
    - On 21 October, when the man told a GP that he would starve himself to death and would not take any medication.
    - On 30 October, when the man repeatedly told the welfare officers and that he would kill himself and that he would leave Forest Bank in a body bag if he did not get home detention curfew.
    - On 4 November, when officers referred the man to the mental health team.
    - On 5 November, when the security department asked an officer to speak to the man after listening to a telephone call which suggested that the man was very low in mood.

<u>Reception</u>

72. A common factor in these interactions is that the person interacting with the man gave greater weight to his presentation and what he told them than to several risk factors which are known to increase the risk of suicide or self-harm. These factors include:

    - It was the man's first time in custody
    - He had relationship difficulties
    - He had been convicted of an offence against his wife
    - He was relatively young
    - He had made a very recent suicide attempt
    - He had been diagnosed with depression.

73. These factors should have been identified when the man first arrived at Forest Bank. The senior custody officer noted that the man had arrived from court with a suicide and self-harm warning (although this did not include details of The man's recent overdose) and that this was his first time in custody. However, the senior custody officer also noted that the man said he had no current thoughts of suicide or self-harm. As he had harmed himself earlier that day, and had to be forcibly removed from the dock when sentenced, it is difficult to see why the officer relied on what the man told him rather than the identified risks. The senior custody officer did not appear to consider it was his responsibility to open an ACCT.

74. The senior custody officer later noted in the senior custody officer's record that a mental health nurse had seen the man and had not raised any concerns. The nurse did not record her assessment on the man's medical record and the healthcare assistant said that she did not discuss the assessment with the nurse. The clinical reviewer has commented in detail on this issue and has recommended that the Head of Healthcare should take further action about the nurse's failure to record the assessment.

75. There is a confused picture of what information was available to each person in reception. However, it is evident that the senior custody officer and the healthcare assistant had enough information which should have led to an ACCT being opened even without the nurse's input. It is important that all staff dealing with prisoners are aware of the factors that can increase the risk of suicide and self-harm, and that they give these the appropriate weight:

76. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, we are concerned that staff relied so heavily on some statements from the man that he would not harm himself, when he had a large number of known risk factors when he arrived at the prison. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors and warnings in comparison to how staff thought the man presented.

77. It is also important that each member of staff takes responsibility for making their own decision whether suicide and self-harm monitoring is required. It appears that the decision on reception was left solely to the discretion of the nurse and that other reception staff deferred to her assessment. National guidance and Forest Bank's own Suicide and Self-Harm Prevention Strategy states that it is the role of all staff to remain alert to the signs and signals which might indicate that a prisoner is in distress. We believe that too many people left it for others to make the final decision about the level of the man's risk.

78. The Suicide and Self-Harm Prevention Strategy requires reception staff to complete a safer custody check list to highlight prisoners who are first receptions, recalls, transfers, charged with murder or domestic violence, or had their status changed as a result of a court hearing. If any of these triggers are noted, the prisoner must be referred to the clinician carrying out the healthcare screen. We have not seen any evidence that this check list was completed. The senior custody officer gave us an overview of the reception process, but he did not mention this check list. Even though the man was seen for a reception health screen, and subsequently by a mental health nurse, we are concerned that this process designed to ensure the safety of prisoners does not appear to have been followed.

79. We believe that there is a lack of clarity over the roles and responsibilities of reception and healthcare staff and reception staff too readily accepted The man's presentation rather than giving due weight to his known risk factors. The failure fully to identify the risk in reception meant that the man did not receive the support he should have done while he was at Forest Bank and meant that some staff who saw him subsequently were unaware of his risks. We make the following recommendation:

The Director 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.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

80. The clinical reviewer has also made several recommendations about the health care arrangements in reception which the Head of Healthcare will need to take into account. These include basing a nurse permanently in reception and better mental health training for healthcare assistants.

Assessment of risk by doctors

81. The man saw three different GPs at Forest Bank. He made comments to all three doctors that we consider should have raised concerns abut his risk of suicide or self-harm. He told The GP that he felt suicidal. He told the second GP that he would "do something" if he did not have any contact with his family over the next few days. He told a third GP that he would starve himself to death. In the context of the man's recent overdose, comments like these should have been very concerning.

82. All three doctors said that they were confident about opening ACCT documents if necessary, or discussing this with other members of staff. However, none of them had been ACCT trained. Forest Bank's Suicide and Self-Harm Prevention strategy states that all staff, including those who are not discipline staff, will be trained to at least foundation level. It is concerning that all three GPs interviewed as part of this investigation said that they had not been trained and that is contrary to the prison's response to a previous PPO recommendation. The Head of Healthcare has told us that GP induction training is being reviewed and that ACCT training is likely to be included. We make the following recommendation:

The Director should ensure that all personnel working in the prison who have contact with prisoners receive ACCT training.

Clinical care

83. The man complained of bleeding from his rectum when he first came to Forest Bank. He attributed this to the overdose he had taken a few days earlier. After he saw the GP on 18 October, The man was monitored in the healthcare unit. Despite being found to be anaemic, he was discharged from the healthcare unit on 21 October. He complained of pain several times in the next two weeks and an officer said that she noticed how ill the man looked when he first arrived on her unit.

84. While it is clear that the man could be difficult to manage, he attributed this to his pain and lack of treatment. There seems to be little doubt that the man's symptoms were genuine. He presented samples of melaena and was anaemic. The post-mortem examination confirmed that he had a gastric bleed. While the bleed was not directly related to the man's death, it was a source of distress for him and, in the letter found in his cell, he made it clear that he did not think that staff at Forest Bank had given him the care that he required.

85. The clinical reviewer found that no nursing assessment or care plan was completed for the man when he was taken into the healthcare unit on 18 October. There was also no discharge plan for him when he was discharged three days later, even though he was anaemic and had said that he would not take food, water or medication.

86. It is important for the continuity of care of prisoners that appropriate plans are made and recorded and that wing staff are given appropriate information when prisoners are discharged from a healthcare setting. We make the following recommendation:

The Head of Healthcare should ensure that robust nursing assessments, care plans and discharge summaries are completed for all inpatients.

87. The clinical reviewer examined the process for referrals to the mental health team at Forest Bank. On 4 November, officers requested that a member of the mental health team see the man as he was refusing to eat and had been

banging in his cell. This call was taken by a member of the mental health inreach team. As the man did not appear to have a serious and enduring mental illness, she tasked the primary mental health to see him. This did not happen before the man hanged himself on 5 November.

88. The Head of Healthcare said that the duty mental health nurse should review the day task list once their immediate duties were completed. The nurse told us at interview that she did not see the task until the evening of 5 November. The nurse also said that usually the primary health care team would get a call direct from the wing, but said that they received no call about the man.

89. It is impossible to say whether an intervention by the mental health team on 4 November, or on the morning of 5 November, would have altered the outcome for the man. However, it is clear to us that the system for wing staff for making urgent referrals is not sufficiently robust. An officer told us that ideally she would have liked someone to have seen the man the same day, but the primary mental health care team did not become aware of the request until the next day and had not reason to believe it was anything other than a routine referral in which case it would be reasonable for the man to have been seen later. We believe that there needs to be a clear referral process so that officers know how to make an urgent or routine referral. We make the following recommendation:

The Head of Healthcare should ensure that there is a robust process for wing staff to refer prisoners directly to the mental health teams and that the referrals are assessed the same day to determine their priority.

RECOMMENDATIONS

1. The Director 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.
   - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

2. The Director should ensure that all staff who have contact with prisoners have received ACCT training.

3. The Head of Healthcare should ensure that there are robust nursing assessments, care plans and discharge summaries completed for all inpatients.

4. The Head of Healthcare should ensure that there is a robust process for wing staff to refer prisoners directly to the mental health teams and that the referrals are assessed the same day to determine their priority.

ACTION PLAN:– HMP Forest Bank – 6 November 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Director should produce clear local guidance 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 newly arrived prisoner when determining their risk of suicide or self harm, including information from suicide and self harm warning forms and PERs. • Open an ACCT whenever a prisoner has recently self	Accepted	Raise awareness around management and sharing of information, personal responsibility and risk at full staff meetings. Make presentation available on staff intranet for those unable to attend. Review local procedures for identifying prisoners at risk of harm to self and produce local guidance for staff which covers all possible sources of information and methods of recording actions taken as a result of risk information. Head of Residence – Safer custody lead and Safer custody Manager attending Safer custody risk management learning day on 24/03/14 at HMP training college – Newbold Revel. Safer custody department will monitor on a daily basis sources of information which may suggest a self harm has taken place and ensure an ACCT book has been opened. The	02/04/14 10/02/14 30/04/14 24/03/14 20/03/14	

	harmed or expressed suicidal intent.		sources of information are Duty incident log, staff handovers, first night observations and Information reports received by security.		
2	The Director should ensure that all staff who have contact with prisoners have received ACCT Training.	Accepted	A twelve month training plan will be devised by the L&D manager which will incorporate: • ACCT foundation for all operational and non operational staff • ACCT foundation for regular visitors, volunteers or agency staff who have direct prisoner contact • ACCT case manager training for all band A and Team leaders • ACCT Assessor training • Regular refreshers Two staff have been identified and booked to attend training as ACCT trainers in order to deliver the training plan with existing trainers.	20/04/15 30/04/14	
3	The Head of Healthcare should ensure that there is a robust process for wing staff to refer prisoners directly to the mental health teams and that the referrals are assessed the same day to determine their priority.	Accepted	Healthcare Manager / In-reach Manager to review local procedures for the Mental Health referral process, including: • Use of S1 Clinical IT system for record of compliance, audit purpose and priority of need. • Raise awareness around referral process within Forest Bank • Referral process placed on intranet,	30/04/14	

			• Promoted at staff meetings • Staff induction process. Monitor referral process for compliance. Feedback compliance data to HOR/Line Manager practice based learning		