PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in September 2012 at HMP Gartree

Our Vision

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

This is the report of an investigation into the death of a man, a prisoner at HMP Gartree. He was found hanging in his cell in September 2012. He was 50 years old. I offer my condolences to his family and friends.

A clinical reviewer carried out a review of the man's medical care in custody. Gartree prison cooperated fully with the investigation.

The man had been sentenced to life imprisonment for the murder of his wife in 2009. He was frequently assessed and monitored as at risk of suicide, including during the period immediately before his death. He often spoke of his intention to kill himself once the arrangements for the custody of his children had been settled.

There is no doubt that both prison and healthcare staff supported the man well during much of his time at Gartree. Indeed, the investigation found considerable evidence of good practice in the suicide prevention monitoring records. Nevertheless, scope for improvement was also identified, particularly when his risk was known to be heightened shortly before his death. There were also weaknesses in medicine management and emergency procedures. However, it is unlikely that better procedures would have led to a different outcome because, ultimately, it is enormously difficult to prevent a person who is intent on killing himself from doing so.

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 **September 2013**

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SUMMARY

1. On 8 November 2009, the man killed his wife and then tried to kill himself. After spending two weeks in hospital, he was arrested and appeared at court. He was remanded to HMP Winchester and monitored under the Assessment Care in Custody and Teamwork arrangements. (ACCT is the suicide prevention system used by prisons to identify and support prisoners who are thought to be at risk of self-harm and/or suicide.) He had four children with his deceased wife and two with his wife's sister. He was concerned where they would live and if he would ever see them again. He later told prison staff that, once the custody of his children with his wife had been decided, he would kill himself.

2. After his conviction and life sentence in November 2010, the man was moved to HMP Gartree in March 2011. Prison staff did not consider him a risk of suicide during the next year but mental health nurses reviewed him often and staff believed he was beginning to settle. After a court case about the custody of his children in March 2012, he was again placed on ACCT monitoring. In April 2012, the court made an interim Care Order for his children, with a view to making a permanent decision in September 2012. He later said that he would not necessarily wait for this permanent decision before killing himself.

3. Over the following few months, staff believed the man was making good progress, mixing more with friends on the wing and attending the gym, a workshop and education. On 13 August 2012, prison staff closed his ACCT. We are not satisfied that an adequate caremap was in place at this stage to allow for the closure of this ACCT. However, two weeks later, on 28 August, the ACCT was opened again after one of his friends expressed concerns about him. Over the next few days, during ACCT reviews, he said that he did not have long left, he was going to make a decision and he had ordered cards to write a goodbye to each of his children. The suicide monitoring arrangements were last reviewed on 30 August, with the next review set for 6 September. We believe the comments he was making should have triggered an earlier review.

4. One morning at the beginning of September, the man was discovered hanging in his cell. He had built a barricade against his door to prevent prison staff getting quick access. A member of staff had checked him at precise hourly intervals overnight and we are critical of the predictability of those observations.

5. The member of staff who discovered the man made no attempt to open his door but waited for assistance. We therefore repeat previous recommendations to Gartree about entering a cell at night where there is an imminent threat to life. We are also concerned that an ambulance was not called until 14 minutes after he was discovered and it took around 15 minutes to open his door. After that was done staff calmly and competently attempted to resuscitate him until the emergency services arrived.

6. The man was prescribed anti-psychotic medication for much of his time in prison. A psychiatrist and a nurse from the mental health team frequently reviewed him. The clinical reviewer is satisfied that his clinical treatment was comparable to that he could have expected in the community. However, for ten days in August 2012 and the first two days of September, just before his death, there is no record of him taking his prescribed medication and no documented reason why he did not. It is not possible to know whether this had any effect on his mental health, or whether he made a rational decision to stop taking it. However, the reason for a prisoner not taking his medication should be recorded, particularly if subject to suicide and self-harm prevention procedures.

7. Overall, staff at Gartree made considerable attempts to engage with the man, manage his anxieties and assist his progression through his sentence. His fears that he would never see his children again, guilt about murdering his wife and concern that he would be an elderly man before his release from prison remained consistent throughout his time in custody. It seems that he had a plan to end his own life, which he had often spoken of, and that there was little prison staff could do to prevent this once he had decided to carry out this plan.

THE INVESTIGATION PROCESS

8. This office was notified of the man's death on 3 September 2012. The investigator visited Gartree on 6 September. She met the deputy governor, a representative of the Prison Officers' Association (POA) and several other members of staff. She collected relevant documents about the man.

9. During the visit, the investigator interviewed the family liaison officer (FLO) who had been in contact with the man's family and the Chair of the Independent Monitoring Board (IMB). The IMB were concerned that, after this and other deaths at Gartree, they did not feel the prison had distributed the notices of the Ombudsman's investigation widely enough. The investigator ensured this was done. No one came forward as a result of the notices.

10. The investigator returned to the prison on 29 October and interviewed six members of staff and three prisoners. She visited the prison again on 17 January to interview three members of staff. Two members of staff were not available as arranged, so these interviews were subsequently conducted by telephone.

11. The local Primary Care Trust commissioned a clinical reviewer to carry out a clinical review of the man's healthcare. He completed his review on 30 November 2012.

12. Her Majesty's Coroner for Leicester City and South District was notified of the investigation and has been sent a copy of this report. HM Coroner provided the man's post-mortem report, which recorded his cause of death as hanging.

13. One of our family liaison officers spoke to the man's sister to explain the investigation process and learn of any questions or concerns she wished to be considered. His sister wanted to know how her brother's depression had been treated in prison and details of the circumstances surrounding his death. She made a number of comments in response to the draft report. These have been addressed in correspondence.

HMP GARTREE

14. HMP Gartree, near Market Harborough in Leicestershire, holds up to 869 life-sentenced prisoners. The local Primary Care are responsible for delivering primary healthcare services in the prison and mental health services are delivered by a NHS Foundation Trust.

HM Inspectorate of Prisons (HMIP)

15. HM Inspectorate of Prisons carried out an inspection of Gartree in November 2010. The Inspectorate found the prison much improved from their previous visit, concluding: "the prison was calm and ordered and prisoners said they felt safe".

16. The Inspectorate noted some good care for prisoners at risk of suicide and self-harm, but said some of the processes could have been better. They said that:

> "Assessments for those at risk were completed quickly, but not all reviews were multidisciplinary or managed consistently. Care plans were satisfactory and assessment, care in custody and teamwork (ACCT) documents indicated good levels of care. Some monitoring was at too regular and predictable times. There was no refresher training in ACCT procedures. The mental health MHIRT provided good support for prisoners at risk."

17. Inspectors reported that health services were improving, with good support from a proactive PCT and the Governor. They described mental health services as well structured and "delivered by cohesive primary and secondary services".

Independent Monitoring Board (IMB)

18. The IMB is made up of independent, unpaid members of the local community who help ensure standards of care and decency are maintained. In their report for the period ending November 2011, the IMB recognised the role of the Governor and his senior management team in bringing improvements to the prison. They commented that the safer custody team was well resourced.

Previous deaths at Gartree

19. The man was the twentieth prisoner to die at Gartree since the Ombudsman began investigating deaths in prison in 2004. Of the previous deaths, four were self-inflicted, the rest were due to natural causes. A number of previous investigations have made recommendations about the need to enter a cell at night where there is an imminent threat to life. This includes three of the most recent deaths due to natural causes. It is therefore of concern that staff still do not seem clear about this policy and a recommendation on this issue is repeated in this report.

20. In the previous self-inflicted deaths, we also made recommendations about closure of suicide and self-harm monitoring and adequate completion of caremaps. Similar recommendations are made here.

KEY EVENTS

21. On 8 November 2009, the man killed his wife and sedated three of their children with sleeping tablets. He then swallowed pesticide and stabbed himself in a suicide attempt. Records indicate that he had been depressed for much of 2009 and had tried to hang himself twice but had not sought any medical help.

22. The man spent two weeks in hospital in a coma and was then arrested on suspicion of murdering his wife. On 27 November 2009, he appeared at Magistrates' Court and his case was committed to Crown Court. He was remanded into custody and admitted to the healthcare centre at HMP Winchester. This was his first time in prison.

23. The next day, prison staff placed theman on ACCT suicide and self-harm monitoring. He said he had no thoughts of suicide or self-harm but staff took account of his suicide attempt after he had committed the offence. ACCT reviews throughout December and early 2010 indicated that he was trying to come to terms with what he had done and was concerned about where his children would live. He had four children by his wife, two of whom were living with his sister and two were in the care of social services. He also had two children with his wife's sister, whom he referred to as his girlfriend.

24. The mental health team reviewed the man. He told them he experienced trances, had suicidal thoughts and also described looking for points from which he could hang himself in his cell. In February, he was prescribed citalopram (an anti-depressant). He said he felt he deserved to die and wanted to commit suicide but could not see a way of doing this. Strengthened string was found in his cell. In March, he was diagnosed as having a depressive illness with psychotic features. His prescription of citalopram was increased and he was also prescribed olanzapine (an anti-psychotic). In April, he told staff that he had added glass to his food after coming to prison and had grown bacteria in an attempt to kill himself.

25. Doctors noted no improvement in the man's mood so, in May, prison medical staff prescribed venlaflaxine (another anti-depressant) instead of citalopram. In July, he became fearful others were going to kill him and his prescription of olanzapine was increased. He told staff that he had found it difficult to come to terms with the death of his wife and having no contact with his children. He said he felt hopeless and worthless. He was monitored under ACCT arrangements for his first ten months in prison and had often been subject to constant supervision and assessed as a high risk of suicide.

26. In September, the man transferred to Ravenswood House (a medium secure unit providing assessment, care and treatment for adults with serious mental illness), and returned to HMP Winchester in November.

27. On 9 November 2010, the man was convicted at Crown Court of the murder of his wife and administering drugs to three of his children. He received a mandatory life sentence, with a minimum period to serve in prison of 15 years

and 19 days before he could be considered for release. He returned to HMP Winchester, where he lived in the healthcare unit and was constantly supervised under ACCT arrangements. The caremap objectives focussed on him coming to terms with the long sentence he had received and his concerns about his children's custody arrangements.

28. Staff tried to encourage the man to move to a main wing so that he could begin to progress in his sentence and get a prison job. In December, his case history noted that Social Services would not allow him contact with his four children by his wife as they did not want to see him. However, he corresponded with his other two children by his wife's sister.

29. In mid-December, the man was very concerned about family court proceedings to decide who would have custody of his children and told staff he had attempted to strangle himself but refused to give any further details about this. As planned, he moved to a residential wing that month and reports in January 2011 indicated that he had settled well.

30. The man's level of monitoring was gradually decreased until the ACCT arrangements were closed on 1 March 2011. At this point, he was reported to be attending education, mixed well on the wing, had settled well and was looking forward to moving to another prison so that he could progress in his sentence.

31. On 15 March, the man transferred to Gartree. The reception health screen conducted the next day noted that he had been taking venlafaxine and olanzapine for 11 months and that he felt well and would like to reduce his medication. He was referred to the primary mental health team for assessment and then to the mental health in-reach team.

32. On 23 March, the man spent two nights at HMP Pentonville for an appearance at the Court of Appeal. At 5.47pm, staff completed a Concern and Keep Safe form (the first stage in the ACCT process) as he said he had stopped taking his medication a week before and refused to resume taking it. He also said he had thoughts of hanging himself six days previously. An immediate action plan was completed at 7.50pm that evening. Staff noted that he needed a mental health assessment but that he was due in court the following day.

33. No further entries were made in this ACCT plan, nor was the assessment completed. Staff set no date for review and did not assess the man's level of risk. When he returned to Gartree on 25 March he was not subject to ACCT monitoring as staff were unaware the ACCT had been opened. The Head of Safety at Gartree said that the ACCT documents were probably filed within his core record so that they were unaware that there had been any concerns at Pentonville.

34. On 29 March, a Registered Mental Nurse (RMN) from the mental health in-reach team assessed the man. He told her that he experienced hallucinations that told him to kill himself, although he would not act on these. He added

that he had recently stopped taking venlafaxine and olanzapine, as he did not like the side effect of weight gain. He told the nurse that he was willing to see a doctor to discuss the alternatives. The nurse noted that she would continue to meet with him to provide support and to monitor his mental health and would arrange an appointment with the doctor. Initially, the nurse met him around fortnightly. She told the investigator that he had quite complex needs, suffering from both depression and psychotic episodes. He was adamant he did not want to restart taking medication and so they met to discuss his fears and anxieties.

35. On 4 May, a psychiatrist assessed the man. The doctor recorded that, since he had stopped taking his medication, he had not slept well and he would restart the medication if his mood deteriorated or psychotic symptoms returned. The RMN continued to review him fortnightly.

36. In response to an application from the man, it had been decided on 7 July 2011 that he should not be allowed contact with his two children by his wife's sister as this was not in their best interests. The decision had taken into account the views of Social Services and the Probation Service. He was informed of this decision, which was explained to him, but he found it difficult to accept. On 20 June, prison staff discovered that he had been speaking and writing to his two children by his wife's sister without staff at Gartree knowing. He was prevented from making further contact with them and managers authorised that his telephone calls and mail should be monitored. He made no telephone calls for the next few months and the monitoring restrictions were later removed.

37. In August, an officer introduced herself as the man's new personal officer. (This is a named officer to whom a prisoner can go for advice or to resolve complaints and who should actively engage with the prisoners they are responsible for and get to know them.) She noted that he had settled well and there were no concerns about his behaviour. She told the investigator that he was a quiet prisoner who never spoke to her about any difficulties he was having. She met him informally over the following year and made frequent entries in his case notes.

38. When the RMN reviewed the man at the end of August, he told her that he was low in mood, felt hopeless and saw angels. She offered him alternative medication but he declined.

39. On 7 November, the mental health in-reach team noted the man was low in mood, with poor sleep and a low appetite. He was trying to cope with feelings of guilt and the following day was the second anniversary of the offence. He told the nurse that he wanted to try to cope without taking any anti-psychotic medication but that he would like something to help him sleep. The nurse noted that she would arrange an appointment.

40. On 24 November, a psychiatrist assessed the man, who reported auditory and visual hallucinations but said that he did not want to take the same medication he had previously. The doctor prescribed aripiprazole (an anti-psychotic) and

promethazine (a sedative). Three weeks later, his sleep had improved but there had been no improvement in his concentration, appetite or mood. The RMN continued to review him, usually monthly.

41. On 9 February 2012, the psychiatrist noted in the medical record that the man continued to experience hallucinations. He increased his prescription of aripiprazole and said that he would review him in three weeks.

42. On 1 March, the man transferred to HMP Winchester for a family court case. Due to an administrative error he was not given his medication until 6 March, when he was also made subject to ACCT monitoring and assessed as a raised risk of suicide. He said that he did not see the point in going on, was an embarrassment to his children and that he would be an elderly man when he was released from prison. He wanted his children to live with his sister but he did not think the judge would allow this. A psychiatrist reviewed him the next day.

43. On 15 March, the man said that, when his children were safe and their custody had been decided, he would commit suicide. Staff assessed him as a high risk of suicide, placed him under constant supervision when he returned from court and set his review for the next day.

44. On 16 March, the man returned to Gartree. He said he was pleased to have returned and staff reduced his observations to hourly after they assessed that his level of risk had reduced. He returned to Winchester on 30 March and he repeated that he would not harm himself until the conclusion of his children's custody case. A report written on 6 April by the man's offender supervisor at Winchester, notes that he had stopped taking his medication and was trying to manage without it. The offender supervisor spoke to him about the risks of stopping medication without medical input and noted that he was still under the care of the mental health in-reach team and psychiatrist.

45. The man returned to Gartree on 11 April. No decisions had been made about the permanent custody of his children during the court hearings in March. At a mental health screening, staff became very concerned as he seemed very depressed and a danger to himself. He appeared confused, could see no reason to live and struggled to engage with staff. He was placed on constant supervision. Over the next few days, he gradually became more positive and the level of observations was reduced.

46. On 19 April, the man again transferred to Winchester for a court case relating to his children's custody. On 27 April, he attended the county court, where the judge made an interim Care Order for the children to live with his sisters. This was subject to review in September, when the court was due to make a decision about their permanent custody. He told staff he intended to attend the next court case but, because he had previously said that he would kill himself once his children's custody had been decided, he was made subject to constant supervision.

47. The man later said that he might not wait for a permanent decision about his children's custody before he killed himself and that he intended to do so when he returned to Gartree. He went back to Gartree on 1 May. He remained under constant supervision in the healthcare centre until 10 May, when he said he was feeling more positive and did not have any suicidal thoughts. In early May, he also began taking his anti-psychotic medication again and, in addition, was prescribed lamotrigine (a mood stabiliser).

48. The man moved to D wing where he said he felt more positive and mixed with other prisoners. He asked about being allowed contact with his two children by his wife's sister and wing staff agreed to make further enquiries about whether this was possible. A member of the prison's offender management unit considered the request but decided that as there had been no significant changes in his circumstances or behaviour, it was unlikely that such contact would be supported by the relevant external agencies at that time. He informed him on 17 May that he would not be permitted contact. Frequent ACCT reviews throughout June and July noted that he found it difficult to cope at night and was using strategies provided by the mental health in-reach team who continued to review him frequently.

49. An SO had begun working on D wing in January 2012 and got to know the man. He first became involved in reviewing his ACCT in May and completed a further three ACCT reviews with him up to the end of July. The SO was not the official ACCT case manager, but covered for colleagues when he was working on the wing.

50. The SO said that during this time the man made "small improvements" and got support from other prisoners. Reviews gradually reduced his level of observations and noted his polite, good, settled behaviour, that he was attending the gym, was employed and was interacting more with other prisoners. The RMN told the investigator that she felt "things started to pick up for him and he felt able to continue with his sentence and move through his sentence". On 23 June, his adult daughter visited him. This was his last visit from anyone before he died.

51. On 13 August, the SO held an ACCT review with the man and the RMN. The SO noted on his record that he had seemed in "better spirits" over the last three weeks (since the previous ACCT review), was more settled on D wing and was pleased that his children were being cared for by his family. He hoped that there would be one more court appearance before permanent custody was decided. He told the SO that he wished to progress through his sentence, had built up relationships with staff and prisoners and felt more able to cope. The SO recorded on the ACCT review that he was:

> "Not 100% sure as case manager, but decision reached between the three of us to close the ACCT document and him to remain on the RMN's caseload. He was asked if he had any negative reports to contact wing staff at anytime."

52. The SO said that they decided to close the ACCT on the basis of the information the man had provided and his demeanour over the preceding weeks. He could not remember if he had checked whether the caremap objectives had been fulfilled. Ideally, the nurse said she would have met him when his ACCT plan was closed but, due to other commitments and the size of her caseload, she was unable to do so. However, the wing staff raised no concerns with her, he continued to attend work and she had no cause for concern.

53. The SO held a post-closure review on 20 August and recorded that the man still needed the support of the mental health in-reach team although his problems were to a lesser degree than previously. In relation to ongoing support, he noted that the man's family were away until early September but that he had support from staff and other prisoners. He also attended the gym, a workshop and education. The SO told the investigator that he seemed okay and he had no concerns about his risk of self-harm.

54. The page of the ACCT document in which staff record triggers and signs which should prompt an immediate review, listed the man's child contact court case, including one due to take place in September. The exact date had yet to be confirmed. The caremap included objectives in relation to his children, medication, education, mental health and support, the latest of which was to be completed by mid-May 2012

55. The SO was working on the wing the next week and said there were no significant developments and the man's demeanour seemed the same as at the time of the post-closure review. On 24 August, a nurse from the mental health in-reach team reviewed him. He recorded that he said he was fine and was managing at present.

56. Prisoner A had known the man for most of his time at Gartree and said he had spent an increasing amount of time with him after his move to D wing and during 2012. He said he became worried that his mental health was deteriorating. He said he stopped exercising and said he had nothing to live for. He told him about his guilt at committing the offence and that there was nothing left in his life as he would be over 60 when released from prison and not allowed to see his children.

57. During the last weeks of the man's life, Prisoner A said he went to his cell after he finished working in the servery at around 5.15pm and stayed there until they were locked in their own cells at about 6.40pm. He told the investigator he was worried about him harming himself and knew he would kill himself one day. He therefore tried to distract him from his thoughts. He also went to his cell every morning to check on his welfare. The SO said he was not aware that Prisoner A went to the man's cell everyday because he was worried about him, but he knew that they were friends.

58. On 28 August, Prisoner A believed that the man's mood had worsened and he was adamant he would kill himself. The prisoner asked the man's personal officer if she could get someone to talk to him. The officer spoke to the SO,

who advised her to speak to him when he returned from an education class and to contact the mental health in-reach team. The RMN came and spoke to him. The nurse said that his mental health had deteriorated, he was much lower than when she had seen him before and he talked of having no hope. He told her that he did not intend to attend the next court hearing when the judge would make a final decision about where his children would live. The nurse thought it would be prudent to reopen the ACCT, although he thought it was unnecessary. She spoke to the SO, who agreed he would open an ACCT.

59. The SO completed the concern and keep safe form around midday and an immediate action plan, which included hourly observations during patrol state and significant conversations in the morning and afternoon. This was the same level of observations and conversations as when the previous ACCT had been closed.

60. A trainee forensic psychologist completed an ACCT assessment with the man later that day at 4.50pm. He told her that he found being prevented from contacting his children very difficult. He said he used to receive progress updates but this had stopped and letters and photographs from his children had been confiscated since May. He also told the officer that he had never been given a reason why he could not communicate with his children while at Gartree. He said children were an important part of his culture, without them his was a hopeless existence and he could lose everything but not his children.

61. The man said that officers had treated him very well but his problems were out of their control and he felt like he had hit the end and was boxed into a corner with no way forward. He spoke about the forthcoming court case in September when the judge would make a final ruling about where his children would live. He accepted that he might never be able to see his children by his wife again and believed they might be better off if he died now so that they could forget about him. He said he had to make a decision about his next steps but he needed to speak to his girlfriend (his wife's sister) before this as there was something he needed to tell her. He did not clarify what he meant by this. He hoped that she would visit in two days time.

62. The man said he was not sleeping well or eating much. He told the psychologist that he wanted to be able to face God. He had ordered a set of cards, which would arrive on 31 August. He wanted to write one to each of his children and set them aside for someone to give to his children later.

63. The next day, 29 August, the SO had an ACCT review with the man, the trainee psychologist and a nurse (the RMN was not working that day). He repeated that he wanted to see his girlfriend but would not disclose why. The nurse recorded that he said that he did not have much time and would write cards to his children that he hoped someone would pass to them. He told staff he would not do anything and would ring his cell bell if had had any "thoughts". Staff assessed him as a raised risk of suicide.

64. The SO recorded that a review would take place after an expected visit from the man's wife's sister the next day and that he would speak to the public protection officer about any possible contact with their children. (The SO thought there might have been a change in policy allowing this.) Although he was worried that the cards to his children might represent "final letters", the SO also told the investigator that he knew the cards he had ordered would not be delivered until Friday 31 August, with the other items he had ordered through the prison shop. He therefore thought that this, along with the expected visit from his girlfriend, were protective factors which would prevent him from harming himself imminently.

65. At 2.30pm on 30 August, the SO and RMN held an ACCT review with the man. He said he felt he had died some time ago and was merely existing in a shell. He agreed to see a psychiatrist the next afternoon after prayers. He was still waiting for the cards so that he could write to his children. The RMN said that he was very open about his feelings of guilt towards his children and that she had assumed he wanted to write the cards to be kept by someone until he was allowed contact with them. She did not consider this particularly unusual. He was assessed as a raised risk of suicide and the next ACCT review was scheduled for 6 September. The SO said that weekly reviews were standard but that, if any risk factors changed, he could be reviewed sooner.

66. The man's girlfriend did not visit him on 30 August as he had hoped, but there was no reference to this in the ACCT review which took place later that day. The level of observations and conversations remained the same at one conversation in the morning and afternoon and hourly observations during patrol state. The RMN said this was at the same level as when the previous ACCT had been closed as his behaviour did not seem to have deteriorated since that time. She said that, although of concern, the way that he talked was typical for him.

67. The RMN told the investigator that the man was very low in mood but she felt there were some "protective factors" as he still wanted to see his girlfriend whom he believed would visit the next week and the SO was still investigating whether he could have any contact with the children he had with her. He was scheduled to see a psychiatrist the next day, 31 August, but the nurse believed that this did not happen as he had already been locked up by the time the doctor went to see him in the afternoon.

68. Prisoner A told the investigator that he had noticed that the man had ordered a lot more food from the canteen than usual that week. He told him it was his "last supper".

69. The SO was working on the wing over the weekend of 1 and 2 September. He saw the man during this time and said he would keep him updated with information from the Public Protection officer about his children. There was nothing in his behaviour which caused the SO concern. When other officers had conversations with him in the morning and afternoon of 2 September, he

said he felt okay and one of the officers reported that he seemed in a good mood.

70. Prisoner B, who lived in the cell next door to the man, said that in the weeks before he died, he heard banging coming from his cell for around 10 minutes every evening between 8.00pm and 9.00pm. He assumed he was moving his furniture to pray as it was Ramadan. On 3 September, around 12.00am, he heard the same noise.

71. The investigator received an anonymous letter from a prisoner. He wrote that during the evening of 2 September, the man said goodbye to his friends and gave away his possessions including food, smoking materials and a DVD player.

72. The SO said both he and his staff were completely unaware that the man had allegedly given away his possessions and said goodbye to his friends. Prisoner A did not see him on 2 September, apart from when he was serving dinner. He thought he looked very distant and preoccupied with his thoughts. He believed that he stayed out of his way on purpose and he did not know anything about him giving his belongings away that evening. He believes he excluded him from this as he knew he would tell staff.

73. The SO last saw the man at around dinner time (5.00pm) on 2 September. He said he was not acting out of the ordinary and gave him no cause for concern. After this, the SO became the orderly officer (in charge of the operational running of the prison) until 8.30pm and so was not necessarily located on D wing. An Operational Support Grade (OSG) took over responsibility for the wing at 5.15pm.

74. Prisoner C lived in the cell next to the man. He said they had never had any long conversations but sometimes borrowed DVDs from each other. Around 6.45pm, he and the man happened to be having a shower at the same time. They talked about day-to-day life and the prisoner said he seemed his normal “happy, bubbly self”. He gave no reason for him to be concerned about him.

75. In the weeks before the man’s death, Prisoner C said he had heard tapping every evening after they were locked up, which he thought came from his cell, although he was not completely sure. The tapping stopped after his death. The prisoner who wrote to the investigator anonymously also said he could hear banging coming from his cell that evening and said that staff did not check on him.

76. An OSG arrived at the prison around 8.15pm and took over responsibility for D wing at around 8.45pm. He received a handover from the day staff which indicated that the man had to be checked hourly as part of his ACCT plan. He was not given any other significant information and told the investigator he was also unaware that he had been giving away his belongings.

77. The OSG checked on the man at 30 minutes past every hour. He did not talk to him during these checks. The OSG said this was normal with the man. At

10.30pm, the SO locked the OSG on the wing, as was the routine. The OSG had a sealed pouch containing cell keys to be opened only in an emergency.

78. During the initial checks up until 11.30pm, the man was noted to be watching television. At 12.30pm, the OSG recorded that he was writing a letter. He then appeared to be asleep when checked between 1.30am and 4.30am. The OSG said that during these checks he shined a torch on him and checked his chest was moving to indicate he was breathing. The OSG also noted that there were a number of boxes and bags in the middle of his cell.

79. In the letter sent anonymously to the investigator, the prisoner alleged that when staff checked on the man at 1.00am, the observation panel was covered and so the officer knocked on the door and asked him to uncover the panel. He said after repeating this request and still getting no reply, the member of staff left. The prisoner said the same thing happened at 2.00am. The OSG denied this was the case and said he was able to see into the cell through the observation hatch.

80. The OSG said he did not hear any banging that evening. As part of his duty, he had to do “pegging checks” which involve visiting every part of the wing every 90 minutes. The OSG denied speaking to the man at any time until 5.30am, when he began the roll check (to ensure all prisoners are in their cells). His cell was one of the first to be checked. He said he opened the observation panel of his cell and could not see him on his bed as expected. He shone his torch around the cell and saw him slumped with his head over his toilet as if he was being sick. The OSG said he then banged on the cell door and shouted to him but he did not get any response. He then noticed that he was hanging from bedsheets tied over his cupboard. The OSG thought that he was not actually suspended but was in a kneeling position with his legs on the ground.

81. The OSG then said he moved to the stairwell on the wing and called a code blue over his radio. This is an emergency code used when a prisoner is unresponsive or not breathing. The incident log recorded it was 5.40am. The OSG estimated he did this less than a minute after getting to the man’s cell. He said that he could see by looking though the door flap that he had barricaded his door but this had not obscured his view. The OSG continued to shout to him and bang on his door until assistance arrived.

82. Officer A and an SO were at the other end of the prison when they heard the emergency call. The SO was ‘Oscar 1’ that evening which meant he had responsibility for the overall running of the prison as well as responding to any emergencies. They went straight to D wing and the officer estimated it took 90 seconds to get to the man’s cell. They looked through his door observation hatch but they said it was completely blocked by the barricade he had built from the furniture in his room and they were unable to see him. It is unclear why they were unable to see him, when the OSG had been able to see him clearly. They tried but were unable to open the cell door. Officer B then arrived at the cell and was also unable to open it.

83. The SO said he then went to the wing office to request an ambulance. He also telephoned the duty governor at home to tell him that they were unable to get into the man's cell. The SO asked Officer B to telephone an officer at home as he was unsure which anti-barricade equipment they needed to open the cell and where it was kept in the prison.

84. Officer B telephoned the communications room to get the officer's home telephone number. The incident log recorded that this was at 5.50am. Officer B telephoned the officer, who said they needed a set of allen keys which can be used to remove part of the door lock so that it opens outwards. They were kept in a safe in the detail office. The SO went to get the tools, which he estimated took two minutes.

85. A nurse had heard the code blue call over the radio and immediately went to the man's cell with the emergency bag, which included a defibrillator and oxygen. She estimated it took her less than three minutes to get there. The nurse told the investigator that she asked for an ambulance to be called when she arrived on D wing as soon as she realised it was his cell, as she was aware he had previously said he would kill himself once his children were settled. The ambulance log noted that they received a request for an ambulance at 5.53am; the incident log notes this at 5.54am. When she got to his cell, officers were still trying to get in.

86. The SO used the allen key to remove the anti-barricade lock from the door so that it could be opened outwards. Those present estimated it had taken between 5-10 minutes from the time they had got to the cell to open the door. The officers then removed the barricade, comprising a big locker, table and boxes, from the man's cell. Officer A said that he could then see him hanging from his shelving unit by bed sheets with a shoelace tied around his neck. He said he was in a kneeling position only a few centimetres above the floor.

87. Officer A immediately cut the sheets and removed the shoelace from his neck. He backed out of the cell to allow the other officer and the nurse to lay him on the floor. The nurse checked for a pulse and signs of breathing but there were none. She told the investigator that he was warm to the touch. The nurse then started chest compressions, which Officer B quickly took over to allow the nurse to apply the defibrillator to him. The nurse also attached an Ambu bag (a mask used to assist resuscitation) to him, which the SO carried on operating. Another officer took over the chest compressions when Officer B became tired. The nurse, SO and Officer B estimated they carried on attempting to resuscitate him for around ten minutes until paramedics arrived.

88. The nurse recorded that officers opened the man's cell door at 5.55am. The ambulance record and incident log indicate that they arrived just before 6.00am. They attached their own defibrillator to him but pronounced him dead at 6.20am. The post-mortem report recorded the cause of death as hanging.

89. Staff told prisoners about the man's death that morning. Prisoner B asked to move cells and they organised this immediately. An operational manager visited him later to check on his welfare.

90. Staff debriefs were held immediately after the man's death and on 30 October. All prison officers the investigator spoke to said they were invited to attend and had felt adequately supported after the death. The nurse was not given the opportunity to attend a debrief and said she would have liked to have been included.

91. After the man's death several letters were found in his cell, all dated 2 September. They were addressed to family and friends and included instructions on what to do if he died. In one letter, he commented that Gartree had too many rules and that he preferred being at Winchester. He wrote that being in Gartree "had a detrimental effect on my mental health". He had not made any telephone calls in the three months before he died. Records for before this period have been destroyed.

92. One of the man's sisters was named as his next of kin. Because she lived a long distance from Gartree at 8.15am, an operational manager contacted the family liaison officer at Haslar Immigration Removal Centre (IRC) which was near to where his sister lived. Haslar's family liaison officer agreed to go to her home to break the news. Meanwhile, an officer was appointed as Gartree's family liaison officer.

93. The family liaison officer went to the man's sister's house, but no one was at home. A neighbour told him that the family would be back from a holiday later that day. He telephoned the operational manager, who asked that he leave a letter asking her to contact the prison.

94. The next day, Gartree's family liaison officer asked the other family liaison officer to return to the man's sister's house as she had not contacted them. He said he was too "wiped out" from the day before. At 11.00am, Gartree's family liaison officer contacted HMP Winchester to see if they could help in breaking the news. No one was available so they asked the local police to inform the sister. Before they did, she telephoned the prison and spoke to the operational manager, who told her the news of her brother's death. Although he recognised that it would have been better to have done so in person, because of the delay he believed this was in the best interests of the family. He telephoned her again later that afternoon and they agreed that she would telephone him the following morning.

95. On 5 September, the man's sister telephoned the prison and said she would like to meet prison staff, so the chaplain and another family liaison officer (the family liaison officer was not available) visited her later that day. A memorial service was held for the man at Gartree, which 140 prisoners attended. His property was returned to his sister and the prison paid a contribution towards repatriating his body to Nigeria.

ISSUES

Clinical Care

96. The clinical reviewer concludes that:

> "It is evident from this clinical review that on many occasions between 02.12.09 and 03.09.12, the man informed prison and healthcare staff that he wished to die and that he planned to end his life … I believe the standard of clinical care provided to him in both HMP Winchester and in HMP Gartree was very good. He consulted with healthcare staff regularly, often more than once daily; he was under regular review by mental health nurses, a nurse practitioner and a psychiatrist. He was prescribed medication that was appropriate for his symptoms."

97. We agree that the man received appropriate care from the mental health in-reach team at Gartree, who made substantial efforts to engage with him and assist him to cope with his fears and anxieties.

98. The clinical reviewer highlights that the man did not take his prescribed medication (an anti-psychotic and mood stabiliser) on 3, 10, 17, 18, 19, 26, 27, 28, 29 and 31 August 2012 (despite requests, the investigator and the clinical reviewer have not been given the prescription records for the first two days of September). There is no record to explain why he did not take his medication.

99. The investigator asked the clinical reviewer whether not taking his medication could have had an effect on the man's mood or mental health. He said:

> "I am unable to provide a definitive answer. It is my experience that some patients derive significant benefit from medication such as he was taking while others do not; also some patients notice if they stop that medication for even short periods while others do not. From the available prescription records I have not been able to correlate well his documented mood with whether or not he was taking his prescribed medication. In addition, missing medication may lead to a change in mood, while a change in mood may lead to a patient missing medication."

100. While it is not possible to determine what impact the man's missed medication had on him, it is essential that the reasons for any missed medication are clearly documented in the prescription record, particularly when a prisoner is regarded as at risk of suicide and self-harm. It is possible that he had decided to stop taking his medication after deciding to take his own life. He had not taken his medication for some days at the time of his last ACCT review on 30 August yet the reviewer was unaware of this so its implications were not discussed. We would have expected a failure to take anti-psychotic medication to trigger a referral to the mental health in-reach team. The failure of the prisoner to collect or take prescribed medication can be a sign of increased risk.

The Head of Healthcare should ensure that the reasons for a prisoner not taking any prescribed medication are clearly documented. When a prisoner does not collect anti-psychotic and other mood altering medication the mental health in-reach team should be informed and the reasons should be discussed at the ACCT review if the prisoner is subject to suicide and self-harm monitoring.

Monitoring and assessing the man's risk of suicide and self-harm

101. The man was assessed as a suicide risk and subject to ACCT monitoring for much of the time he spent in prison. He stated a clear intention to kill himself many times and often spoke of feelings of hopelessness and worthlessness. He was primarily concerned about his children - whether he would ever see them again and who would look after them while he was in prison. He also spoke of his guilt at murdering his wife and his sentence length. He told a number of members of staff that, when the custody of his children had been decided, he would commit suicide.

102. There is much evidence of good practice in the ACCT documentation and from the investigator's interviews with staff. For example, at Gartree the man attended frequent multi-disciplinary ACCT reviews which usually included wing staff and a nurse from the mental health in-reach team. The RMN told the investigator that she felt involved in the ACCT monitoring arrangements and was always invited to reviews. Where necessary, if she was not available, another nurse from the in-reach team attended on her behalf.

103. The triggers which would potentially lead to the man committing suicide were often discussed, as were his feelings of guilt, hopelessness and worthlessness. The investigator was satisfied that, generally, staff at Gartree had a good understanding of the issues affecting his risk.

104. On 23 March 2011, an officer at Pentonville completed a concern and keep safe form and immediate action plan following the man's transfer there for a hearing at the Court of Appeal. He said he had thought about hanging himself six days before and had refused to take his anti-psychotic medication. Contrary to the ACCT process set out in Prison Service Instruction (PSI) 64/2011, Safer Custody, no assessment or case review was completed within 24 hours. No further entries were made in the ACCT and it was not formally closed.

105. The man returned to Gartree on 25 March. Pentonville had not entered the ACCT plan onto his computerised core record (where Gartree staff would have been alerted to it), nor did they telephone Gartree about the open ACCT before his transfer as would have been expected. The Head of Safety said the paper documentation relating to the ACCT was probably filed within his core record. The governor said that if Gartree had been aware of the ACCT they would have completed a case review immediately on his return and entered the details within the ACCT database held at Gartree.

106. We are concerned that arrangements at Pentonville did not ensure that after the concern and keep safe form was completed the process outlined in PSI 64/2011 was followed.

The Governor of Pentonville should ensure that when a concern and keep safe form is completed, an assessment and first case review occurs within 24 hours, the ACCT is logged on the prisoner's core record and if the prisoner is transferred, the receiving prison is alerted to the ACCT.

107. The man was not subject to ACCT measures between March 2011 and March 2012. This was the only substantial period during his time in prison when he was not monitored. During this time, he received appropriate support from the mental health in-reach team and wing staff.

108. The man was monitored again under ACCT arrangements in March 2012. Following a county court appearance in April, an interim Care Order was made for his children, with a view to a decision to be made about permanent arrangements in September 2012. He had told staff that he would not necessarily wait for a formal decision before killing himself.

109. During the following months, wing staff and the mental health in-reach team thought the man was making progress. He interacted more with other prisoners, had a prison job, went to the gym and seemed more able to cope. During the ACCT review on 13 August, a SO, RMN and the man decided to close the ACCT due to the apparent progress he had made.

110. The SO recorded that those present were not completely sure about closing the ACCT. He told the investigator that he is never entirely sure about closing an ACCT and always has doubts about the remaining risk a prisoner presents to himself. He also said that he still believed that the man had a plan to kill himself which he had refused to tell anyone. However, he was satisfied the ACCT could be closed as he had support from wing staff and was to remain on the RMN's caseload.

111. The RMN told the investigator that there is always a risk in stopping ACCT monitoring. However, she said the man assured her and the SO that he would ask for support if he needed it. She said he had done so in the past so she was satisfied that he would do this in the future.

112. PSI 64/2011 states that ACCTs can:

> "only be closed once all the caremap actions have been completed and the Case Review Team judges that it is safe to do so in that the risk posed by the prisoner has reduced."

113. The caremap is one of the most important elements of the ACCT process, on which those responsible for supporting the prisoner determine and list the actions necessary to address the prisoner's issues and reduce his risk of suicide. The investigator asked the SO why there were no issues or goals

recorded on the caremap with targets after 10 May. He was unsure but said the caremap was a working document to which issues could be added and any developments noted. If there were no new issues, he said staff would refer to old ones.

114. The SO said that, when closing an ACCT, he might look back at the caremap to see if all the issues had been addressed but he could not remember whether he had done this when he closed the man's ACCT. The RMN did not believe it was her responsibility to keep the caremap up to date but thought that she could contribute to it.

115. We are concerned that the SO and nurse did not feel sure about closing the ACCT and the SO still believed that the man had a plan to end his life which he had not told anyone. There was also no up to date caremap by which his most recent issues could be measured to ensure they had been adequately addressed.

116. On 28 August, after concerns were raised by the man's friend, Prisoner A, another ACCT was opened. He told the ACCT assessor that he felt like he had reached "the end" and it might be better for his children if he died now. He said he needed to speak to his wife's sister, who he hoped would visit on 30 August, before he made a decision. He also said he had ordered cards which would arrive on 31 August so he could write one to be kept for each of his children. He expressed similar sentiments at the ACCT review the next day during which he said he did not have much time left. A review was set for the following day after the expected visit from his wife's sister.

117. On 30 August, the man's wife's sister did not visit as he had hoped. This was not recorded in the ACCT review or on the caremap as it should have been. There does not seem to have been any direct conversation with him about any plans he had as a result. It was also not recorded clearly on the caremap that the cards he wished to write to his children would be delivered on 31 August. The SO acknowledged that the visit with his wife's sister and date of delivery of the cards could have been recorded clearly on the caremap. As noted above, the ACCT reviewer was unaware that he had stopped taking his medication. The SO said he assessed him as a "raised" risk to himself and felt the level of observations and conversations remained appropriate. This was because he had not actually harmed himself or attempted suicide but had only thought about it.

118. The next ACCT review was set for 6 September. The RMN and SO said that weekly reviews were generally standard for a prisoner such as the man, but that the ACCT could be reviewed sooner if there were any additional concerns. While we must be careful not to rely too heavily on the benefit of hindsight, he was talking about making a "decision" after seeing his wife's sister (the SO said this could happen over the weekend), he did not have much time left and wanted to write cards to his children (which would be delivered on Friday 31 August). We believe the ACCT review should have been set for the weekend to enable further discussion about his feelings of

suicide and any plans he might have had after his cards were delivered and after he had had a visit from his wife's sister.

119. The staff and prisoners the investigator spoke to had been unaware that the man had allegedly been giving his possessions away and saying goodbye to other prisoners on the evening of 2 September, until after his death. This suggestion was made in an anonymous letter from a prisoner to the investigator. The SO had also heard a similar rumour from prisoners on the wing after his death.

120. The OSG said he would have contacted the SO on duty if he had been aware of this and the SO said he would have reviewed the ACCT and considered placing the man on constant supervision. These actions would have been appropriate in the situation and staff cannot be criticised for a lack of action regarding information of which they were unaware. Indeed, his closest friend and the prisoners the investigator interviewed were also unaware of his alleged actions that night.

121. During the 12.30am check on 3 September, the man was writing a letter. The OSG said it was not unusual for him to be writing at that time of night. The OSG also noticed bags and boxes in his cell which he said did not worry him as his cell was often very "cluttered". The SO said he had been unaware of him packing his belongings into boxes but that even if he had seen boxes this would not necessarily been cause for concern. He said prisoners often cleaned their cells and pulled boxes out from under their beds or in his case he often had to pack his belongings when he was transferred to HMP Winchester. Within this context, it is understandable that staff were not concerned about the boxes in his cell.

122. On the night that the man died he was checked every hour at thirty minutes past the hour by the OSG. Such regular observations also took place on other occasions during his time in prison. This is not in line with PSI 64/2011 which states that: "Observations must be at unpredictable times, e.g. twice an hour as opposed to every 30 minutes". The Inspectorate also highlighted that they had found such regular observations to be an issue during their last inspection.

123. The OSG said that since the man's death he had amended his practice so that if a prisoner is required to have hourly observations, he will complete them five minutes earlier each time. For example at 1.20am, 2.15am, 3.10am and so on. He altered this as a result of talking to other OSGs after the death. He said that some OSGs completed their observations this way and others at regular intervals. Either way, it is apparent that a prisoner would be able to predict when their next observation is likely to take place.

124. Staff whom the investigator interviewed said that the man had built a very effective barricade from his locker, table and boxes. A number of staff referred to him having made a plan to end his own life even though he would not share this and those the investigator spoke to were not shocked when this occurred. The deputy governor commented that she thought that the support

and monitoring offered by staff had probably lengthened his life. We recognise that this may well have been the case and the way he was discovered appears to indicate a determination to end his life. Nevertheless we make the following recommendation:

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

- **completing observations at irregular and unpredictable times within the time constraints set;**
- **setting appropriate caremap targets, checking these at each review and only closing ACCTs once all the caremap actions are complete;**
- **giving reasoned consideration to the regularity of ACCT reviews and the risk factors involved for the prisoner.**

Entering a cell at night

125. Although he would have been unable to open the door had he tried, due to the barricade the man had built, the OSG did not attempt to go into the cell when he found him. The OSG said that this was because he was unsure if he was genuinely hanging as his legs were close to the floor. The OSG said he would only go into a cell on his own if he discovered a prisoner hanging and only then if he could see that there was a gap between the prisoner's feet and the floor. He said he would not enter a cell on his own if someone was bleeding or having difficulty breathing, as he would be worried for his own welfare if the situation was not genuine. However, he also said that "common sense" was needed in such situations and he would contact the communications room first if he intended to go into a cell.

126. Officer A told the investigator that a member of staff should never enter a cell on their own at night, as it was too dangerous. An SO said that night duty staff all carry emergency pouches with cell keys in which they can open to go into a cell if there is an imminent threat to a prisoner's life.

127. The Chief Executive Officer of the National Offender Management Service, wrote to prison governors in January 2010 to remind them that:

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

128. Gartree's local policy for "unlocking a prisoner at immediate threat to life" at night (reviewed June 2012), repeats this instruction and also states that:

> "Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Duty Governor and Night

Orderly Officer and an individual member of staff may enter the cell on their own."

129. Three deaths at Gartree since October 2010 have involved a delay entering the cell at night. While the OSG's decision in this case seems unlikely to have caused a delay since anti-barricade equipment was needed to open the door, we are concerned that there remains a lack of clarity amongst staff about when they would enter a cell alone at night. In an emergency, time is critical and it is important that all staff who work in prison at night are prepared to enter a cell in order to preserve life. Staff can and should alert the night orderly officer when they are doing so, which helps to ensure safety. In response to a previous death, Gartree indicated they would ensure staff were sufficiently trained on this point by December 2012. This was after the investigator completed the majority of staff interviews in relation to the man's death. Nevertheless, since this recommendation has been made several times previously, we again repeat it here:

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

Timing of emergency response

130. The clinical reviewer concludes:

> "Trained staff were quickly on scene and his cell was entered as rapidly as possible, delayed only by the significant barricade that had been erected inside the cell. As soon as his body was reached the ligature around his neck was removed and cardiopulmonary resuscitation begun by a trained nurse and trained prison officers. The paramedics arrived very quickly and continued the resuscitation procedure."

131. We agree that staff reacted competently in trying to resuscitate the man. However, we are unsure whether the response was as swift as the clinical reviewer suggests. In the incident log, Officer A and the SO all said that the code blue call happened at 5.40am. The investigator discussed the timings of the emergency response with the OSG, who acknowledged that his initial call of "code blue" might have taken place at nearer to 5.40am (rather than 5.30am as in his statement).

132. According to the incident log, Officer B telephoned the communications room to get an officer's home telephone number at 5.50am. This was after the SO and Officer B had got to the cell and discovered they were unable to open the man's door. The same log recorded that the ambulance was requested at 5.54am and arrived at the prison five minutes later. Both the SO and a nurse said that they had requested an ambulance as soon as they got to the cell, whereas this log indicates a delay of fourteen minutes. Unfortunately, the log completed by an officer at the cell was not started until 6.10am.

133. There is therefore some discrepancy between those responding to the emergency and the timings recorded on the incident log. One of the main purposes of the incident log is to provide an accurate account of timings and we have seen nothing to indicate that the timings in the logs were incorrect. The log indicates a delay of 14 minutes after the man was found before an ambulance was called.

134. The Director of Offender Health and the Chief Executive Officer of the National Offender Management Service wrote to all prison governors and prison healthcare managers on 17 February 2011 to reiterate previous guidance about the importance of calling an ambulance as soon as possible in an emergency. Any delay can have a significant impact on the prisoner's chance of survival. An ambulance should have been called as soon as officers suspected that the man was hanging in his cell.

The Governor should ensure that an ambulance is called immediately in an emergency where there are grave concerns about the immediate health of a prisoner.

135. According to the incident log, there was a delay of ten minutes between the code blue call and officers attempting to find the anti-barricade equipment. Those responding to the emergency estimated it took between 5-10 minutes to get into the man's cell after they had got there. Officer A estimated it took 20 minutes from the time of the code blue call to cutting him down.

136. The nurse and discipline staff whom the investigator spoke to said that everything happened very quickly and there were no unavoidable delays. The nurse estimated they opened the door at 5.55am which, given the timings recorded on the incident log, seems likely to be accurate. This means there was a delay of fifteen minutes between the officers reaching the cell and opening the door.

Dealing with the barricade

137. Since the man's cell could not be opened inwards due to the barricade he had built, staff needed an allen key to undo the hinges of the door and open it outwards. The SO asked Officer B to telephone an officer at home to find out where the anti-barricade equipment was kept. During interview, the SO said that he knew where the tools were kept but he did not know which were needed.

138. Officer A and the OSG did not know where the anti-barricade equipment was kept and Officer B said he only knew of some equipment on the other side of the prison. Officer B said that, with hindsight, all officers should be aware of the location of the anti-barricade closest to where they are working in the prison.

139. There was uncertainty about what equipment was needed to open the door and where it was kept. Those present estimated it took between 5 and 10 minutes to open the man's door after reaching the cell. The OSG said it

seemed to “take ages” to find the anti-barricade equipment. In an emergency such as this, where the man had hanged himself, every second is crucial in an emergency response. Relying on an officer to answer the telephone at home at 5.40am to locate the equipment is not an acceptable contingency plan. Prison staff should be aware of where equipment to open cell doors outwards is stored, and should be able to access it quickly and know how to use it.

The Governor should ensure that in an emergency prison staff are able to get into a barricaded cell without delay.

RECOMMENDATIONS

The National Offender Management Service accepted all the recommendations. Their response to each recommendation is annotated below.

1. The Head of Healthcare should ensure that the reasons for a prisoner not taking or being offered any prescribed medication are clearly documented. When a prisoner does not collect anti-psychotic and other mood altering medication the mental health in-reach team should be informed and the reasons should be discussed at the ACCT review if the prisoner is subject to suicide and self-harm monitoring.

   "Any prisoner refusing to collect medication is logged via healthcare and the reasons for this are now investigated and documented. Those who are refused medication will have the reasons documented on System1. Issues surrounding medication are discussed at each ACCT review whilst maintaining patient confidentiality where relevant."

2. The Governor of Pentonville should ensure that when a concern and keep safe form is completed, an assessment and first case review occurs within 24 hours, the ACCT is logged on the prisoner's core record and if the prisoner is transferred, the receiving prison is alerted to the ACCT.

   "HMP Pentonville currently adheres to the stated recommendations on this action plan.
   - *Concern and keep safe forms are completed and an assessment and first case review takes place within 24 hours.*
   - *The ACCT is logged on the prisoner's core record via the alert system on NOMIS.*

   If the prisoner is being transferred, the safer custody equivalent in the receiving establishment is informed by an e-mail which is followed up with a phone call."

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

   - completing observations at irregular and unpredictable times within the time constraints set;

   - setting appropriate caremap targets, checking these at each review and only closing ACCTs once all the caremap actions are complete;

   - giving reasoned consideration to the regularity of ACCT reviews and the risk factors involved for the prisoner.

   "The completion of ACCT reviews and compliance checks has now been escalated to Custodial manager level with assurance for:

   - *Irregular observations being completed within time constraints*

- *CAREMAP targets being set appropriately and being monitored and updated at each relevant milestone*
- *Ensuring that the timings for reviews are justifiable and documented.*

A monthly sample check of all ACCTs is also undertaken by the Head of Residence and Safety to ensure consistency in the quality of care given to those prisoners on ACCT."

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

"All staff have been made aware of the need to enter a cell if the situation is deemed to be life threatening and there is no obvious risk to their own safety. All night staff have signed a statement of this information with a clear briefing from the nights managers to this effect. This is also checked by senior managers on ad hoc night procedures compliance checks. The LSS also reflects this instruction to staff."

5. The Governor should ensure that an ambulance is called immediately in an emergency where there are grave concerns about the immediate health of a prisoner.

"Staff have been advised that they should ensure an ambulance is called in any situation where a prisoners appears to be in medical distress without delay."

6. The Governor should ensure that in an emergency prison staff are able to get into a barricaded cell without delay.

"An information notice to all staff has been published in addition to night staff being briefed as to the whereabouts of anti barricade tools to ensure no delay is experienced in opening a cell. A training session for all Custodial Managers - who act in a managerial capacity throughout the day and night – has been arranged for May 2013 (to accommodate new CMs who are due to start at HMP Gartree in May 2013)."