



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a prisoner on 4 March
2014 at HMP Forest Bank**

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 prisoner who suffocated himself at HMP Forest Bank on 4 March 2014. He was 26 years old. I offer my condolences to the man's family and friends.

The investigation was conducted by a senior investigator. A clinical reviewer reviewed the clinical care the man received in prison. HMP Forest Bank cooperated fully with the investigation.

The man had a history of mental health problems and had been detained in a psychiatric hospital from September 2013. In January 2014, he was arrested while on leave from hospital and remanded to prison custody. The man arrived at Forest Bank on 14 January 2014. Police and court custody staff had been concerned about the man's risk of suicide and self-harm and passed this information to the prison but no action was taken when he arrived or, on 20 January, when the man told a nurse that he had thoughts of self-harm. During February, the man missed appointments with his mental health caseworker and the GP who had been asked to consider whether he needed antidepressant medication. A scheduled appointment with a psychiatrist in early February was postponed until the end of March.

On 4 March, an officer found the man unresponsive on his bed with a plastic bag over his head. The officer called an emergency and other members of staff arrived quickly. There was a short delay before an ambulance was called, but it was apparent that the man had been dead for some time.

I am concerned that reception staff and others at the prison did not take full account of the man's evident risk factors for suicide and self-harm when he first arrived at Forest Bank and throughout his time there. Another recent investigation into a death at the prison found similar failings in safer custody procedures on reception, which the prison says has led to a comprehensive review. Sadly, this came too late for the man, but underlines the importance of ensuring that those at risk of suicide and self-harm are identified and supported as soon as possible. I am also concerned that there was a lack of effective mental health support at Forest Bank for the man who had, until he was remanded to prison, spent several months detained in hospital under the Mental Health Act.

The 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

December 2014

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SUMMARY

1. The man had a history of mental health and substance misuse problems and, from September 2013, had spent several months in hospital detained under the Mental Health Act. On 14 January 2014, the man was remanded to HMP Forest Bank after being charged with burglary and assault while he was on home leave from hospital. He had been in prison a number of times before.
2. Police and court custody staff were concerned about the man's risk of suicide and self-harm and completed a warning form to alert prison staff. The warning form was received in the prison, but it is not clear what happened to it after that and no action was taken. An officer in reception did not record any concerns about him. A healthcare assistant who completed an initial reception health screen did not consider him at risk of suicide and self-harm, but referred him to a mental health nurse because of his demeanour and because he had been a detained patient. The nurse did not identify him as at risk, but did not see the suicide and self-harm warning form or the concerns about his risk identified in his escort record.
3. At a mental health assessment on 20 January, the man said he had fleeting thoughts of self-harm. The nurse did not assess him as at risk but made an appointment for him to see a psychiatrist. The psychiatrist was unexpectedly away for the arranged date in early February and a subsequent appointment was then re-arranged for March. This meant that the man did not see a psychiatrist at Forest Bank before he died. During February, the man missed appointments with the GP and his mental health caseworker, but the reasons were not investigated and recorded. On 26 February, he told a nurse administering medication that he did not believe it was working as he was having violent thoughts. She referred him to the mental health in-reach team, but his caseworker was on leave at the time and an appointment was made for him to see her on 4 March.
4. At around 5.05am on 4 March, an officer discovered the man lying unresponsive on his bed with a plastic bag over his head. The officer radioed for emergency help but did not go into the cell. The control room did not call an ambulance until they checked with the night manager that one was required. Two night managers arrived very quickly and removed the plastic bag from the man's head but they, and healthcare staff who arrived shortly after, found clear signs that the man was dead. Paramedics arrived quickly and confirmed that the man had been dead for some time.
5. We are concerned that none of the staff who encountered the man identified that he was at risk of suicide or self-harm, despite the concerns identified in the suicide and self-harm warning form and his person escort record. It is not clear what happened to the warning form after it arrived at Forest Bank. The man said on more than one occasion that he had thoughts about self-harm or was in low mood but no one began suicide and self-harm prevention procedures, even though he had a range of risk factors, including that he had been a detained psychiatric patient at the time of his arrest. We are not satisfied that the man received the level of mental health support we would expect to see for

someone in his position. Although it would not have affected the outcome for the man, control room staff did not call an ambulance immediately they received the code blue emergency message, as they should have done. We make four recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
7. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.
8. The investigator visited Forest Bank on 10 March and spoke to the Director and staff involved in the man's care. He saw the houseblock and cell where the man had lived. The investigator obtained copies of the man's prison and medical records and interviewed staff. He gave the prison verbal feedback about the preliminary findings of the investigation and followed this up in writing. At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations at the end of this report.
9. We notified HM Coroner for Bolton of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted the man's father to explain the purpose of the investigation and invite them to raise matters they wished the investigation to consider. The man's father identified the following issues:
 - The man's father had visited him on 6 February and noticed his son's appearance had altered and he had grown a beard which was out of character. He said that his son had been in and out of hospital with mental health problems for a number of years and it was apparent at this visit that he was unwell and that his mental health had deteriorated. His father said this should have been obvious to those who knew him.
 - The man's father believed that his son had been admitted to the prison's healthcare centre at some point and questioned whether a move to a houseblock had been appropriate.
 - The man's father wanted to know how his son could have had access to the bin liner he used to suffocate himself and questioned why he had not been more closely supervised.

The man's family received a copy of the draft report. They pointed out one factual inaccuracy and this report has been amended accordingly.

HMP FOREST BANK

11. 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

12. 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. Inspectors found that attendance rates at GP clinics were poor.

Independent Monitoring Board

13. 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 its 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

14. There has been one self-inflicted death at Forest Bank since 2010, which occurred in November 2013. The investigation report was sent to Forest Bank after The man's death. In the report, we recommended that the Director should provide clear guidance for identifying prisoners at risk of suicide or self-harm and that all staff who have contact with prisoners should be ACCT trained (see below). The prison accepted these recommendations and told us guidance had been provided to staff and that ACCT training will be provided to all healthcare and prison staff.

ACCT - Assessment, Care in Custody and Teamwork

15. 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 be at irregular 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Detention under the Mental Health Act 1983

16. Section 2 of the Act allows a person to be detained or 'sectioned' for assessment, or for assessment followed by medical treatment, for up to 28 days. Section 3 of the Act allows a person to be detained in hospital for treatment if, as with Section 2, it is necessary for his health, safety or the protection of others. Patients can be detained for up to six months and this can be extended after that, if necessary. Detention can be ended at any time by the consultant in charge of the patient's care if no longer necessary.

KEY EVENTS

17. The man had been in prison a number of times. When he was in prison at HMP Manchester, on 14 October 2010, he told staff that he had previously self-harmed by cutting his wrist and was managed under suicide and self-harm prevention procedures (ACCT) for a short period. The man told prison staff that his mother's early death from suicide had affected his life and that he previously been sectioned under the Mental Health Act.
18. On 11 September 2013, a friend was concerned about the man's paranoid behaviour and took him to his local hospital. He was admitted to the hospital and detained under the Mental Health Act for treatment.
19. On 22 October, a mental health nurse recorded that the man had been paranoid, verbally aggressive and threatening to staff and patients many times. The man said he used cannabis frequently to help prevent paranoia and the nurse recorded that he continued to lack insight into the impact cannabis had on his mental state.
20. On 22 November, a ward sister recorded that the man became angry when he was challenged about his cannabis use and had been warned that his visitors would be stopped and refused entry if they smelt of, or were suspected of carrying, cannabis. Doctors were concerned that the man might not continue to take his medication in the community and prescribed pipotiazine palmitate antipsychotic medication by depot injection. (This means the medication is slowly released into the body over a number of weeks.)
21. On 24 November, the ward sister recorded that the man had recently absconded from the hospital and had returned two days later. He said that he had smoked cannabis and used alcohol and became verbally aggressive when challenged. On 19 December, a ward sister noted that the man had returned from a period of home leave during which he had been arrested for burglary and assault. He had admitted using illicit substances (cannabis and crack cocaine) and said that he felt he had left the hospital too early. The man said he was in a very low mood and that his life was not worth living. He said he would stab someone to death and take an overdose of paracetamol if he was released from hospital.
22. The man had a further period of home leave on 23 December. He was due to return to the hospital on 13 January 2014, when it was intended to change his Section 3 detention to a Community Treatment Order (under which a person continues to receive treatment when they leave hospital, and is required to abide by certain conditions). However, that day, the man was arrested on further charges of burglary and theft.
23. On 13 January, a community psychiatric nurse saw the man at a local police station to assess his fitness to plead to the charges made against him and because he had threatened to throw himself from a building if he was released. The nurse contacted a consultant psychiatrist at the local hospital who advised that the man's Section 3 order would be rescinded if he was remanded to

custody. The nurse recorded that the man understood the court process and had the capacity to plea. He refused to have the depot injection which he was due to receive every fortnight and she advised the custody sergeant that the man should be observed every half hour, and reassessed if he was to be released. He needed to receive his depot injection the next day. She asked that the court should be made aware of his threats to kill himself if he was released from custody, in which case a medical review would be needed. In the event of the man being remanded to custody, the nurse noted that prison reception staff should be told of his threats and should arrange an urgent medical review.

24. In a statement to the police, a solicitor said that he had known the man for over 15 years. On 13 January, he had gone to the police station to act on behalf of the man but, when he tried to speak to him about the charges against him, the man would not speak to him. The solicitor said that this was the first time the man had refused to talk to him.
25. On 14 January, when the man was taken to court, police custody staff recorded on the Person Escort Record (PER) that the man had suicidal thoughts and had threatened to kill himself if he was released from court. They also noted that the man had mental health problems because of his use of cannabis. (The PER form accompanies prisoners on all journeys between custodial environments, including police custody, prisons and court.)
26. At about 9.30am, the man told a court custody officer that he suffered from schizophrenia and had been detained under the Mental Health Act after taking a drug overdose. He said that he did not feel mentally well and was hearing voices. The custody officer completed a suicide and self-harm warning (SASH) form (which escort and court custody staff use to alert others if they are concerned about a risk of suicide or self-harm.) She wrote that the man's behaviour was bizarre and that he appeared disorientated.

HMP Forest Bank

27. During the afternoon of 14 January, the man was remanded to prison from Magistrates' Court, charged with burglary and assault. He arrived at Forest Bank in the early evening. The PER and suicide and self-harm warning form were handed over to Senior Prison Custody Officer A, the reception manager, at around 6.10pm. Someone (it is not clear who) had written "open ACCT" on the front page of the copy of the PER form received by the investigator. The suicide and self-harm warning form completed at court, was not with the papers the prison gave to the investigator and the prison could not find it after the man's death. GEOAmeey Escort Services gave the investigator a copy of the form, which Mr A had signed to confirm he had received.
28. Mr A told the investigator that he did not remember escort staff raising any concerns about the man when he arrived. He did not recall seeing the note about opening an ACCT form on the front cover, and said this would have been unusual as he would have expected someone at court to have written "open SASH" instead. He would have then queried whether a suicide and self-harm

warning form had been opened. Mr A did not remember the man, or recall receiving a suicide and self-harm warning form for him. Mr A said he routinely read through the notes on the summary information on the inside of the PER form but would not usually go any further.

29. Mr A told the investigator that he asks prisoners whether they have previously self-harmed or have any current self-harm issues. Mr A said that if he had had any concerns about the man's risk of suicide or self-harm he would have discussed them with the reception healthcare assistant.
30. Officer B then saw the man as part of the reception process, but told the investigator he could not remember him. He said that he would have read the PER and would have asked the man about the comments he had made while in police and court custody. Despite the concerns identified on the PER, he did not open an ACCT.
31. Healthcare assistant C carried out an initial reception health screen and recorded on the prison medical record (SystemOne) that the man had made threats on his own life while in police and court custody. The man told her he had no thoughts of self-harm. However, as he had recently been sectioned under the Mental Health Act and was acting strangely, she asked a primary mental health nurse, Ms D, to assess him. Ms C told the investigator that she did not discuss any suicide and self-harm concerns with Nurse D, and that she would have opened an ACCT had she been unable to speak to a mental health nurse.
32. Nurse D wrote in the medical record that she had seen the man during a previous period in custody and that they discussed his current treatment. She was unsure about his status and arranged with the duty governor for him to be admitted to the prison's healthcare centre while she obtained further information about his detention under the Mental Health Act. Hospital staff informed Nurse D that, after the police had informed them of his arrest, they had extended his leave, but they had not been aware that the man had been remanded to prison. Nurse D spoke to a community psychiatric nurse who confirmed the man's medication and that his detention under the Mental Health Act had not been rescinded.
33. Nurse D told the investigator that she had not checked the man's medical record before she saw him, so she had not seen Ms C's comments noting that he had recently threatened to kill himself. She said he did not seem as unwell as when she had seen him before. Nurse D wrote in his medical record that the man said that he did not have any thoughts of suicide or self-harm. She did not recall seeing the man's PER or the suicide and self-harm warning form and said that Ms C had not mentioned any concerns about his risk of suicide or self-harm. She said that if she had identified that the man was at risk of suicide or self-harm she would have opened an ACCT. Nurse D sent an electronic task to the mental health in-reach team to contact the hospital for further information about the man's care.

34. On 15 January, Nurse E, from the mental health in-reach team, contacted the Hospital. Staff said the man had last received his depot injection on 27 December and had not received a planned injection on 10 January. Nurse E asked whether the man's consultant, Dr F, would rescind his detention as he could not be remanded to prison while subject to Section 3 of the Mental Health Act. As Dr F was in court, his assistant said she would arrange for another doctor to discharge him from hospital care. The man declined support from the substance misuse team. A locum prison doctor, Dr G, saw him and recorded that the man was alert, did not feel delusional or have any hallucinations and maintained eye contact. Dr G prescribed a depot injection which a nurse gave to the man.
35. On 15 January, Officer I recorded on the man's prison record that she had received a telephone call from someone from the prison's safer custody team to say that the man had said he was going to kill himself. There is no record that any further action was taken and no one opened an ACCT as a result of the information.
36. On the morning of 16 January, Dr J, a prison doctor, prescribed antibiotics as the man had a groin infection. That evening, the man told Nurse D that he wanted to move out of the healthcare centre. She explained that until the prison had received confirmation that he had been discharged from hospital care he would not be allowed to move. Nurse D told the investigator that the man appeared content with this. She said that he appeared happy and pleasant and she had no concerns about him.
37. The next day, the hospital sent a fax confirming that the man had been discharged from detention under the Mental Health Act. The man was informed and as there was no longer any reason for him to remain in the healthcare centre he moved to Houseblock H1 (the prison's first night centre) that afternoon. There is nothing in his prison record to indicate that any information about his risk of suicide or self-harm was passed to staff on Houseblock H1.
38. During the afternoon of 20 January, Nurse E completed a mental health assessment and noted that, according to his hospital records, the man became verbally aggressive and threatening when he used cannabis. She recorded that the man appeared relatively settled both in mood and mental state. He said that he had previously been diagnosed with schizophrenia, depression and psychosis and had a family history of suicide and depression. The man said he felt suicidal when he was depressed and he was currently depressed because he had been remanded to prison. He said that he had started using cannabis when he was 11 and smoked it to take his mind off things.
39. The man told Nurse E he had fleeting thoughts of self-harm as he thought he would be homeless when he was released from prison. She told him that accommodation would be found for him before he was released and his rent would be paid while he was on remand. After being reassured about this, the man said he had no current thoughts of self-harm. He said he was in a low mood because he was in prison but did not have any paranoid thoughts or

hallucinations. Nurse E recorded that the man was not currently experiencing psychotic symptoms, his body language was nonchalant, his speech was normal and his mood was euthymic (when the range of emotions is neither depressed nor highly elevated). She decided not start ACCT procedures.

40. The mental health assessment plan was to monitor the man's mood, offer support to address his substance misuse and book an appointment for him to see the prison psychiatrist. (An appointment was made for 3 February but was cancelled as the psychiatrist was on holiday. A further appointment made for 6 February was then rearranged for 21 March as referrals to the psychiatrist were relisted according to assessed clinical urgency. This meant that the man never saw a psychiatrist while he was in Forest Bank.) The man moved to Houseblock E1 (the induction unit) later on 20 February.
41. Nurse E was on long-term sick leave during the investigation. Her line manager, Ms K, told the investigator that Nurse E had received advanced suicide risk training and had attended ACCT training. Ms K said Nurse E would have assessed the man on both his presentation and his history. Ms K said she had no concerns about Nurse E's ability to assess the risk of suicide and self-harm.
42. During the afternoon of 26 January, the man's behaviour was described as erratic and bizarre. He was incoherent and unable to walk in a straight line or stand up straight. Nurse L recorded that the man was very pale, appeared inebriated and had to be helped to walk down stairs. She decided to admit him to the healthcare centre for observation as it was not clear whether he had taken an illicit substance. The man refused to have his blood pressure taken, but his pulse rate was recorded as 100 beats per minute (within normal range). Nurse L recorded that his pupils were large and non-reactive. When she checked on him later that day, he was asleep on his bed.
43. On the evening of 26 January, Nurse M, a mental health nurse, saw the man in the primary mental health triage clinic. She noted that he felt in low mood and was not sleeping well but said he did not have any thoughts of suicide or self-harm and maintained good eye contact during their meeting. They discussed referral to the prison doctor about prescribing medication for his depression and Nurse M booked a doctor's appointment for 30 January.
44. Nurse E tried to review the man's mental health on 27 January, but he would not engage with her. An officer told Nurse M that the man had admitted taking synthetic cannabis (Black Mamba) the previous day. It was later recorded that the man had kept ringing his cell bell, spitting at the observation panel in his cell door and asking to leave the healthcare centre. He flooded his cell and was aggressive towards staff. However, the man apologised and cleaned his cell before he returned to his houseblock (E1) that day.
45. On 29 January, the man moved to Houseblock A2 and received a depot injection that day. Nurse M recorded that the man had said that the medication agreed with him and there were no further concerns. On 30 January, the man did not attend the doctor's appointment which Nurse M had booked on 26

January for the doctor to consider whether he needed antidepressant medication. The reasons why the man did not attend were not recorded.

46. On 31 January, the man's solicitor saw him to take instructions for his forthcoming trial. In his statement for the police, the solicitor wrote that the man was calm and gave clear instructions. He had no concerns about the man's mental state or his behaviour when he saw him.
47. On 11 February, the man did not attend his appointment with Nurse E. This appointment was recorded only in the diary records for the mental health in-reach team and not on his medical record. No one established the reason why he did not attend.
48. On 12 February, Nurse D gave the man his depot injection. He told her that he was having problems on his houseblock and she advised him to speak to officers on the houseblock about this.
49. On 14 February, Officer N recorded that the man had made a promising start on the unit and was polite and compliant. Officer N wrote that the man was in regular contact with the mental health in-reach team and staff were aware of his previous behaviour. Three days later, on 17 February, the man moved to Houseblock B1. The reason for the move was not recorded.
50. On the morning of 20 February, the man told Officer O that he wanted to move to another houseblock as he was in debt. He told her that the debt was from Houseblock A2 and had followed him to Houseblock B1. Officer O did not ask him about the nature of his debt or whether he was being threatened and intimidated as a result, but arranged for him to move to Houseblock E1 later that day. Officers did not record any further interactions with staff in the man's prison record.
51. On 21 February, the man did not attend another appointment with Nurse E. Again, the appointment was recorded only in the in-reach team diary and was not on his medical record. As previously, the reason why he did not attend was not followed up or recorded.
52. On 26 February, Nurse P saw the man to give him his depot injection. He told her he suffered side effects from the medication and had previously received procyclidine to counteract them. Nurse P said that she would check his prescription. The man said that the depot injection was not reducing his violent thoughts, and said that he was not seeing a nurse regularly. Nurse P sent an electronic task using the medical computer system to check that the man was being supported by the mental health in-reach team. She was later told that his case worker, Nurse E, was on leave, but an appointment had been booked for him to see her on 4 March when she returned. This information was not recorded on the medical record and neither was the fact that he had missed his appointments on 11 and 21 February.
53. On Thursday 27 February, Dr Q, a prison doctor, prescribed procyclidine to relieve the side effects of antipsychotic medication but did not see the man in

person. There is no record that the man received the medication before he died. The next day, Friday 28 February, the man moved to cell 52 on the first floor of Houseblock F1.

54. On 3 March, Officer R was the night patrol officer on Houseblock F1. At around 10.30pm, Officer R made a routine check that all prisoners were in their cells. In his statement to the police, he said this would usually take him around 20 minutes. He did not know the man as he had just returned from a period of leave and could not recall checking his cell specifically or remember if he was awake or asleep at the time.
55. At around 5.05am on 4 March, Officer R began the morning roll check. When he arrived at the man's cell, he opened the observation hatch, shone his torch inside the cell and saw the man lying on the bed with a plastic bag over his head. Officer R noticed the bag was not moving. He kicked the door but got no response from the man and then radioed a code blue (an emergency code indicating that someone is not breathing or is unconscious).
56. Officer R did not go into the cell but ran to the wing office to check the man's records. He told the investigator that he did not know why he had not gone straight in. The night orderly officer, Mr S, and a senior prison custody officer, Mr T, had arrived at the office in response to the code blue. Mr S and Mr T opened the man's cell and removed the bag from his head. Mr S was unable to find a pulse and told Mr T that he thought the man was dead.
57. According to the communication log, the code blue was received at 5.08am. Control room staff then asked Mr S for more information and he instructed them to call an ambulance immediately. An ambulance was called at 5.10am.
58. Mr S told the investigator that the plastic bag was not a cell bin bag, which he described as being of very thin material. In his statement to the police, Mr S wrote that the man had used a clear heavy duty plastic bag, which he thought was a wing bin bag. Mr S said that the man's neck was marked where the bag had been tied tightly around his head.
59. Nurse U and Mr V, a healthcare assistant, arrived at the cell. The man was lying on the bed and the plastic bag had been removed from his head. His skin was cold and his eyes were open with fixed dilated pupils. Nurse U could not find a pulse or any trace of respiration. The man's body showed signs of hypostasis (purple or violet spots which appear three to six hours after death) under his arms and on his back so they did not attempt cardiopulmonary resuscitation. Paramedics arrived at the cell at 5.32am and confirmed that the man had been dead for some time. They pronounced death at 5.35am.

Contact with the man's family

60. A prison chaplain who acted as the prison's family liaison officer, together with a prison manager, went to the man's father's home and informed him of his son's death. The chaplain maintained contact with the man's family. In line

with national policy, the prison offered financial assistance towards the cost of the man's funeral, which took place on 14 March 2014.

Support for staff and prisoners

61. A debrief was held later on 4 March for the staff involved in the emergency response who were offered the support of the prison's care team. Notices were issued to staff and prisoners informing them of the man's death. Officers and members of the chaplaincy supported prisoners. Staff reviewed prisoners being managed under ACCT procedures in case they had been adversely affected by the man's death.

Post-mortem and toxicology reports

62. A post-mortem examination recorded the cause of death as asphyxia. The toxicology report showed no alcohol, common drugs of abuse or medication.

ISSUES

Mental Health

63. Section 117 of the Mental Health Act states that aftercare services must be provided to patients who have been detained under Section 3 of the Act. Usually, this will be delivered using the Care Programme Approach, under which each patient is allocated a care co-ordinator, given a written care plan and has multi-disciplinary care review meetings. The man was detained at a local hospital for several months under Section 3. He was due to return to hospital in 13 January 2014, when doctors planned to continue his care using a Community Treatment Order. However, by this time he had been arrested.
64. In prison, the man did not see a psychiatrist as two appointments were cancelled because the psychiatrist was unavailable. He did not attend two appointments with the mental health in-reach team, for reasons that are unclear. (The appointments themselves were not noted in the medical record as they should have been.) He received his depot injection the day after he arrived at Forest Bank and then at regular intervals, and saw members of the primary mental health team when appropriate. However, it is clear from the medical record, that the primary mental health team were unsure what interventions were planned by the in-reach team.
65. We are concerned that the man did not receive an effective level of mental health care at Forest Bank. He never saw a psychiatrist and after, 27 January until his death, no one from the mental health in-reach team saw him or followed up the reasons why he did not attend appointments. We consider that the level of mental health support was not sufficient for a man who had so recently been a detained patient under Section 3 of the Mental Health Act. We make the following recommendation:

The Head of Healthcare should ensure that prisoners who have recently been detained under the Mental Health Act 1983 receive appropriately prioritised mental health support when they arrive at Forest Bank.

66. As noted, the man missed two appointments with the mental health in-reach team in February. He also missed a GP appointment after being referred for antidepressant medication. No reasons were recorded and there is no evidence that this was followed up. The mental health in-reach appointments were not recorded in his medical record. At the last inspection of Forest Bank, HM Inspectorate of Prisons noted that attendance at GP clinics was poor and made a housekeeping point that clinic attendance rates should be examined to reduce the non-attendance rate, suggesting this is an on-going problem. We make the following recommendation:

The Head of Healthcare should ensure that healthcare appointments take place as planned by accurately noting the appointment in the medical record and reviewing and recording the reasons if an appointment fails.

Assessment of risk of suicide or self-harm

67. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action". A list of potential triggers includes previous deliberate self-harm, mental illness and early days in custody.
68. The man had a number of risk factor for suicide and self-harm when he arrived at Forest Bank. He had a history of mental health problems and self-harm and had been managed under ACCT procedures when he had previously been in prison. The man had been diagnosed with schizophrenia, which is listed as a risk factor in PSI 64/2011. Research¹ shows that people diagnosed with schizophrenia are up to twelve times more likely to kill themselves than others. From September 2013, the man had been detained under Section 3 of the Mental Health Act in a local hospital. While in police and court custody, the man had threatened to harm himself and escort and court staff had completed warning forms. He also had a family history of suicide. When the man arrived at Forest Bank on 14 January 2014, his mental health problems and history of self-harm were noted by more than one member of staff, but no one identified him as at risk of suicide and self-harm.
69. Some prison staff knew the man and remembered him from previous sentences. It is possible that their familiarity with him outweighed all the other information available when assessing his risk. Although a suicide and self-harm warning form had accompanied the man to Forest Bank, it was not recorded in his prison record and does not seem to have been shared with the healthcare staff who saw the man when he arrived. This did not help them make a holistic assessment of his risk. Ms C, the healthcare assistant, did not see the suicide warning form, but did see the comments on his escort record. She asked Nurse D, a mental health nurse, to assess the man, but principally because he had been a detained patient under the Mental Health Act. She did not mention any information about the risk of suicide and self-harm and Nurse D did not recall seeing this information, although Ms C had noted in his medical record the concerns written on his escort record.
70. In the report of our investigation into the most recent previous self-inflicted death at Forest Bank in November 2013, we found similar issues about the transfer and management of information in reception. We noted that each member of staff should make their own decision when assessing whether an ACCT should be opened, and not leave the decision to others - a factor which seems to have applied again in this case. It is not clear why Mr A or Officer B, who appear to have been aware of the suicide and self-harm warning form in reception, did not consider or discounted opening an ACCT. Ms C said that

¹ Reassessing the Long-term Risk of Suicide after a First Episode of Psychosis. Archives of General Psychiatry. December 2010

she would have opened an ACCT had Nurse D not been available, but if she had concerns about his risk we consider that she should have opened an ACCT herself or at least discussed her concerns with Nurse D and other staff.

71. Several other opportunities to support the man under ACCT procedures were missed. When Nurse E saw the man, on 20 January, he told her had fleeting thoughts of self-harm and felt suicidal when depressed. She recorded he was in low mood as he was on remand but that he had told her he did not have not current thoughts of suicide or self-harm. Nurse E had access to the man's records from the community and his prison medical computer record which should have identified further concerns. There is no record that she explored with him the threats he had made to kill himself while he was in police and court custody. On 26 January, the man apparently took an illicit substance and was admitted to the prison's healthcare centre for observation. He told Nurse M he was in a low mood, but denied having any thoughts of suicide or self-harm. Nurse M arranged a doctor's appointment to discuss the possibility of prescribing an antidepressant. On 26 February, the man told Nurse P that he had violent thoughts. At interview, Nurse P said she considered that the man's violent thoughts were towards others rather than himself. We consider that, taken in conjunction with the man's static risk factors, these were further opportunities to have considered supporting him using ACCT. The man also reported being in debt to other prisoners which would have further increased his vulnerability, but there is no record that this was considered.
72. In response to our investigation report into the self-inflicted death at Forest Bank in November 2013, the prison produced a continuous improvement plan aimed at improving all aspects of safer custody at Forest Bank. In particular, it notes that all staff should be confident in initiating the ACCT process and includes a plan to review the early days in custody procedures to ensure that staff receive more support to help them identify prisoners at risk of suicide and self-harm. We welcome this initiative and consider that there is a need to ensure that identification of risk in reception needs to improve as a matter of priority as evident risk factors when the man arrived at Forest Bank were overlooked. We make the following recommendation:

The Director and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular this should ensure that reception and induction 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.**

Access to plastic bags

73. The man's father was concerned that he was able to obtain the plastic bag with which he was able to kill himself. As the man had not been judged to be at risk of suicide and self-harm, there would have been no reason to suspect that he would use such a bag to end his life. While the bag he used appears to have been one used for collecting rubbish on the wing rather than those normally used in prisoner's cells, there would have been little reason for prison staff at the time to have prevented him from having the bag, even if they were aware of it. Even if the man had been assessed as at risk of suicide and self-harm and monitored under ACCT procedures, it is likely that he would have been able to obtain such a bag.

The emergency response

74. When Officer R discovered the man with a plastic bag over his head he did not go into the cell, but immediately radioed an emergency code blue. The communications room logged the emergency code at 5.08am and called an ambulance at 5.10am, after checking with the night orderly officer, Mr S, that one was needed. Paramedics arrived at the cell at around 5.32am, 22 minutes after being called.
75. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, issued in February 2013, contains mandatory instructions for prisons to have a protocol on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that an ambulance is called immediately when a medical emergency is called over the radio network. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. Forest Bank's emergency response protocol was issued on 5 March 2013. It contains an instruction that the communications room should call an ambulance immediately, but this was not done. It should not be necessary to make further checks after the code is received. While there was only a slight delay, which in the man's case would not have altered the outcome, it is important that there is no unnecessary delay in calling an ambulance. We make the following recommendation:

The Director should ensure that the communications room calls an ambulance as soon as a medical emergency code is received.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners who have recently been detained under the Mental Health Act 1983 receive appropriately prioritised mental health support when they arrive at Forest Bank.
2. The Head of Healthcare should ensure that healthcare appointments take place as planned by accurately noting the appointment in the medical record and reviewing and recording the reasons if an appointment fails.
3. The Director and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular this should ensure that reception and induction 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.
4. The Director should ensure that the communications room calls an ambulance as soon as a medical emergency code is received.

Action Plan HMP Forest Bank 4th March 2014

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners who have recently been detained under the Mental Health Act 1983 receive appropriately prioritised mental health support when they arrive at Forest Bank	Accepted	<p>All Prisoners received at Forest Bank who have either been under the care of Secondary Service Mental Health Teams in the community, or recently detained under the Mental Health Act, are automatically placed on the Mental Health In-Reach Team case load.</p> <p>Prisoners who are under the care of the In-Reach Team are allocated an In-Reach Nurse, who is responsible for gathering information on the prisoner's medical history to inform the clinical assessment of any immediate risk to the prisoner and others, and safeguarding concerns.</p> <p>A SystemOne task referral is sent to the mental health care provider (GMW) for prisoners identified on reception as having contact with secondary mental health services.</p> <p>A weekly multi-disciplinary "Single point of referral" meeting is held to discuss interdepartmental referrals to secondary services.</p>	In-Reach Team Completed	
2	The Head of Healthcare should ensure that healthcare appointments take place as planned by accurately noting the appointment in the medical record and reviewing and recording the	Accepted	All GMW healthcare appointments are recorded in the prisoner's clinical notes, together with the reasons for any missed appointments. Appointments will be re-arranged to ensure that	Healthcare Manager completed	

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No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	reasons if an appointment fails		<p>the prisoner is seen in due course by the In-Reach team.</p> <p>Any Consultant Psychiatry Clinics that are cancelled or changed are clearly recorded in the Consultants Clinic Diary together with the reasons.</p> <p>The Head of Healthcare will receive a visiting consultant's exception report weekly highlighting clinics cancelled, steps taken to ensure missed appointments take place at next available clinic.</p> <p>GMW are required to submit a monthly data submission to the Head of Healthcare in accordance with the newly implemented PHE Health and Justice Indicators Performance recording all Visiting consultants, sessions, patients called up, patients seen, DNA . The report is monitored by NHS England. Quarterly contract review meetings take place between GMW/NHS England</p>		
3	<p>The Director and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular this should ensure that reception and induction staff.</p> <ul style="list-style-type: none"> · Have a clear understanding of responsibilities and the need to share all 	Accepted	<p>Presentations have been at staff meetings on ACCT and the need for staff to share known information about risk of suicide and/or self-harm.</p> <p>The presentation is available on the staff intranet for all staff to review and included the June "Forest Bank Informer".</p>	<p>Head of Residence and Head of Security and Operations</p> <p>Completed</p>	

Action Plan HMP Forest Bank 4th March 2014

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<ul style="list-style-type: none"> · 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. 		<p>Local procedures and guidance for staff concerning the identification of prisoners at-risk of self-harm will be reviewed. The revised guidance will identify possible sources of risk related information, and remind staff of the need to record action taken following receipt of information about risk.</p> <p>The requirement for ACCT case reviews to have multi- disciplinary input from those involved in the prisoner’s care will be addressed in both the above guidance and and a staff notice.</p> <p>The Safer Custody department will monitor sources of risk related information daily, including the Duty incident log, staff handovers, first night observations and information reports received by Security, to ensure that the opening of ACCTs have been considered and opened appropriately.</p>		
4	The Director should ensure that the communications room calls an ambulance as soon as a medical emergency code is received	Accepted	The Director re-issued guidance on 26.09.14 to remind staff that an ambulance should be called immediately when a medical emergency code is received.	Director - Completed	