PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Haverigg in May 2014

Our Vision

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

This is the investigation report into the death of a man who was found hanging in his cell, at HMP Haverigg, on 9 May 2014. He was 23 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. The clinical reviewer reviewed the clinical and mental healthcare the man received while at Haverigg. The prison cooperated fully with this investigation.

The man was sentenced to three and a half years imprisonment in November 2013 and began his sentence at HMP Preston. The man's community GP records detailed two serious suicide attempts and this information was noted in the man's prison medical records. On 24 December 2013, the man transferred to Haverigg, but healthcare staff did not notice this information and took the man's word that he had not previously self-harmed.

The investigation identified a number of concerns about the man's care at Haverigg. There were weaknesses in the assessment of his mental health and, even though the man was prescribed an antidepressant that had a known association with increased suicide risk, this prescription was not subsequently reviewed. Other prisoners had threatened the man because of apparent drug and tobacco debts, but staff did not investigate this properly and support him appropriately. They did not consider whether the bullying increased the man's risk of suicide and self-harm. Information from the man's partner about his state of mind was not properly acted on and he was also upset about not being allowed to attend a family day where he had hoped to spend time with his new baby daughter.

While I accept that it was not immediately obvious that the man was at imminent risk of suicide, I am concerned that there were a number of missed opportunities to identify his risks. Reception procedures at both Preston and Haverigg were not sufficiently thorough and there was poor communication of information to help get a holistic assessment of his risk.

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 **February 2015**

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SUMMARY

1. The man arrived at Preston prison on 28 October 2013 on remand for charges of burglary. He was diabetic and dependent on insulin. The police had recorded a history of self- harm, and that he had taken an overdose four weeks earlier. The police passed this information to the prison in the Person Escort Record (PER) that accompanied the man.

2. The man told reception staff that he had no history of self-harm and no thoughts of harming himself. The reception staff did not note the information from the police about his recent suicide attempt. Healthcare staff obtained the man's GP records which recorded two suicide attempts; the recent overdose and a previous attempt to kill himself. The staff entered this information in his electronic prison medical record, but did not review his risk in the light of the information.

3. On 29 November, the man was sentenced to three and a half years in prison. On 24 December, he transferred to Haverigg. The reception nurse at Haverigg did not read the previous healthcare records and see the information about the man's earlier suicide attempts. He told her he had no history or thoughts of harming himself. However, some family issues were causing him distress and the nurse referred him to the mental health team. On 6 January, a doctor prescribed him an antidepressant to help him cope until he saw the mental health team. The doctor had not seen the record about his previous suicide attempts.

4. On 12 February, a mental health nurse assessed the man and noted that he appeared sad and tearful. He was worried about his parents' health and upset that he had not yet seen his new baby. The nurse had not noticed that previous suicide attempts were recorded in his medical record and was not aware that he had been prescribed an antidepressant. She scored his risk of self-harm as zero and referred him to a psychological therapist.

5. It appears that the man had been in debt to other prisoners for 'spice' (a synthetic form of cannabis) and tobacco and was under pressure to repay the debt, which continued to increase. In February, other prisoners assaulted him. The man said that he was being bullied, but he refused to name the prisoners responsible. Staff monitored the man under anti-bullying procedures, but only for a week and without holding a review.

6. No one considered whether the reported bullying might put the man at risk of suicide and self-harm, although he told prison staff he felt down. Information from his partner about his risk was not passed on effectively.

7. We are not satisfied that prison staff appropriately identified and assessed the man's risk of suicide and self harm. We make six recommendations about the need for better assessment of risk, mental health services, the need for appropriate responses to bullying and threatening behaviour, and about the emergency response.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Haverigg informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

9. Spectrum Community Health commissioned a clinical reviewer to review the man's clinical care at Haverigg.

10. The investigator obtained copies of the man's prison and medical record. She interviewed 14 members of staff and four prisoners. The clinical reviewer, attended the interviews with healthcare staff.

11. We informed HM Coroner South and East Cumbria of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process and to allow them to identify issues they wanted the investigation to consider: His parents and partner were concerned about his previous suicide attempts and that he had asked his partner to bring drugs into the prison. They had the following questions:

    - Was the man being bullied?
    - Did doctors prescribe antidepressants?
    - Had postal orders/money gone missing?
    - Was the man in debt for tobacco or spice?
    - When was the man last checked on 9 May?
    - Why had the toxicology report noted no trace of insulin in the man's body?

13. The man's family received a copy of the draft report. They raised some issues that do not impact on the factual accuracy of the report. The prison responded to say that a debrief had been held for staff, so paragraph 71 has been amended to reflect this.

HMP HAVERIGG

14. HMP Haverigg is a medium secure prison which can hold 644 sentenced men. Cumbria Partnership NHS Foundation Trust provides healthcare services at the prison. Cumbria Health on Call provides out of hours GP services and Greater Manchester West NHS operate a substance misuse service,

Her Majesty's Inspectorate of Prisons

15. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Haverigg in January 2014. HMIP found that the systems to evaluate risk and monitor the reported levels of violence among prisoners had improved since their previous inspection, but the quality of investigations into alleged or suspected incidents of bullying was often very poor and there was evidence of under-reporting. Many of the interventions in the published violence reduction policy had not been implemented. There were many opportunities for bullying, but there was little staff supervision.

16. HMIP noted that the number of incidents of self-harm was low. The Safer Custody committee meetings were well attended and minutes reflected that issues were well debated. Entries in ACCT documents were generally good, although care-maps were sometimes weak. Attendance at ACCT reviews was occasionally poor.

17. The security department received a high number of security information reports, but these were not always dealt with sufficiently quickly.

Independent Monitoring Board

18. 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. The most recent IMB report for 2012-2013 noted that prisoners expressed their frustrations through rooftop protests, dirty protests, bullying, self-harm, fighting and assaults on staff. However, overall, the IMB considered Haverigg to be a safe environment with good relationships between staff and prisoners. The IMB noted that, due to reductions in staffing, safer custody issues were not always followed up effectively and efficiently and that the operation of the anti-bullying scheme had particularly suffered.

Previous deaths at Haverigg

19. The last self-inflicted death at Haverigg was in July 2007. There were no significant similarities with the circumstances of the man's death.

KEY EVENTS

20. The man was arrested on 27 October 2013 and taken into police custody. The man's police custody record identified that he took insulin daily and that he had last taken it on 26 October. It recorded that he said he did not have mental health problems, but noted that he had tried to harm himself by taking an overdose four weeks earlier. The man said he still felt down and police observed him every 30 minutes. A nurse examined him, measured his blood sugar and gave him insulin.

21. The next morning, 28 October, Furness and District Magistrates' Court remanded the man to prison custody. A police officer completed a pre-transfer risk assessment for the man's transfer to HMP Preston. The officer gave details of the man's recent overdose and a previous suicide attempt on the Person Escort Record, but did not consider that the man was at risk of suicide or self-harm at the time. This information went with the man to Preston.

22. On 29 November, the man was sentenced to three and a half years imprisonment for burglary. (He had previously served a sentence for burglary and other offences in 2009 at HMYOI Lancaster Farms.)

HMP Preston

23. A nurse assessed the man when he arrived at Preston and discussed the man's diabetes. The man said that he had not received any medication for mental health problems, had not tried to harm himself before and had no thoughts of suicide or self-harm. There is no record that the nurse read or noted the police information about the man's overdose four weeks previously. The doctor saw the man shortly afterwards and prescribed diabetic medication (novo rapid penfill cartridges - an insulin product) which the man kept in his possession to self-administer.

24. The next morning, 29 October, the man's GP faxed his community medical records to the prison's healthcare department. A pharmacy technician, noted in the man's medical record that the man had 'active problems' including a deliberate overdose in September 2013 and an incident in 2007 when he had stabbed himself and needed a laparotomy (stomach) operation as a result. The man had seen a psychiatrist and child mental health services in 2007. The fax was scanned into the SystmOne electronic medical records, and a separate record made as 'free text'. (It is possible to attach 'flags' on SystmOne to alert the reader to information such as self-harm risk, but this did not happen for this entry. Staff can read entries made as 'free text' by reading back through the medical records.)

25. After he had seen the GP records, the doctor noted in the man's medical record on 29 October that the man had taken an overdose in September. He put a task on SystmOne for someone from the mental health team to see the man.

26. Later that day a mental health triage nurse, assessed the man. The mental health nurse noted that the man did not have any current thoughts of harming himself, had no suicidal ideation and denied having any history of harming himself. (Despite clear evidence to the contrary in his medical record.) The mental health nurse also noted that the man did not display any evidence of mental health problems and that no intervention was needed. The nurse did not refer to the man's recent overdose, which was the reason that the doctor had referred him for a mental health assessment.

27. On 29 November, the man was sentenced to three and a half years. A nurse assessed the man when he returned from court. He said he was pleased with the sentence, as he had expected more. He said that he had no thoughts of suicide or harming himself.

28. On 24 December, the nurse assessed the man as fit to transfer to HMP Haverigg that day. He noted that the man received medication for diabetes and said he had no thoughts of harming himself.

HMP Haverigg

29. The nurse assessed the man when he arrived at Haverigg on the afternoon of 24 December. The nurse noted that the man was diabetic, and arranged a locum doctor to prescribe his medication. The nurse did not note his previous suicide attempts but referred him to the mental health team because she considered he had a number of risk factors, including that he was concerned about his parents' poor health and the fact that he had been unable to see his baby who had been born two days earlier. She identified the man as having 'situational unhappiness'. As it was Christmas Eve, the nurse competed a secondary screen immediately afterwards.

30. The nurse told the investigator that she did not see a previous SystmOne entry made at Preston, about the man's overdose in September, as she did not have time to read through his records for the reception health screen. She said that at a reception health screen nurses rely on what prisoners tell them and the man had said that he had no history of self-harm and no thoughts about harming himself.

31. That night, the officer recorded in the man's case notes that his partner had given birth to their baby two days earlier. The man was concerned about how much credit he had on his telephone account and that he had just found out that his mother had serious health problems.

32. On 5 January 2014, an officer noted that the man had no immediate concerns, except he was worried about his mother. The next day, a doctor prescribed the man insulin. He noted that the man said his mood was low because he was worrying about his family and had not yet seen his new baby. The doctor recorded that the man was 'not suicidal', but he was concerned that he was not sleeping well. He prescribed a course of 28 sertraline (an antidepressant) to be taken daily. He did not diagnose depression, but

thought the medication might help the man cope while he we waited to see someone from the mental health team.

33. The doctor told the investigator that he had not had time to read all of the man's medical record and, like a nurse he had not seen the entry about the man's previous suicide attempts as it was not flagged.

34. The man had a meeting with his offender supervisor on 14 January to discuss his sentence plan objectives. The man told her that he had referred himself to attend a number of courses to address his offending behaviour. She arranged to see him again on 29 January to follow these up. (This was later changed to 14 February as the man had a visit on 29 January.)

35. On 30 January, the doctor saw the man again who continued to take sertraline. The doctor noted that he was still waiting to see someone from the mental health team, after his referral on 24 December. An appointment for 10 February did not go ahead as the man did not attend. The reason was not recorded.

36. On 12 February, the nurse saw the man for the mental health assessment he had missed two days earlier. She noted that the man seemed sad and became tearful at times, which she considered was because of his circumstances. He told the nurse that he had no thoughts of harming himself or of suicide. The nurse noted that the man seemed low in mood and that he had told her he had difficulty sleeping.

37. The nurse told the investigator that she had not been aware of the man's previous suicide attempts or that he had been prescribed sertraline. She had access to the man's medical records, but he had not read anything about his previous self-harm or noted his prescription. The nurse identified some risk factors, such as the man's worries about his parents' health and that he had not yet seen his baby, but scored the man's likelihood of self-harm as zero. She regarded him as vulnerable because of he was upset at missing the birth of his daughter, so referred him to a psychological therapist.

38. On 18 February, the man told the unit manager that he had been punched and head butted while he was in the education department, the day before. He knew who the prisoners who attacked him were, but did not want to give their names and said he that he did not know why they had assaulted him. The man said he would speak to staff if the problems continued. Staff began to monitor the man under the prison's anti-bullying procedures and opened a support booklet, designed to allow staff to quickly identify and resolve any continuing problems and offer support.

39. The next day, the man told the officer that one of his assailants had approached him in a threatening way. The officer made a note of this, but took no other action. Staff did not record anything further in the support booklet that day. On 20 February, the officer noted that she had spoken to the man the night before and he had said he would let staff know if anything else happened. Over the next four days, staff entries in the booklet noted no

concerns. There is no record that anyone reviewed the position on 25 February as the anti-bullying policy required. There were no further entries after that.

40. On 20 February, the doctor saw the man, mainly to review the management of his diabetes. The doctor noted that the man continued to take sertraline, but did not review his mental health. When interviewed, the doctor said that he had assumed that the mental health team was now responsible for the man's mental health care).

41. On 4 March, the man told a nurse that he had been vomiting during the night. The nurse noted that he appeared very tired and looked pale and had been monitoring his own blood sugar and administering his own insulin. The nurse advised a light diet and to make an appointment to see a doctor if the symptoms persisted. There is no record that the man continued to feel unwell.

42. A family links worker, employed by a charity to support prisoners' families, spoke to the man's partner on 5 March in the visitors centre. His partner said that the man had been refused permission to attend a previous family day and was keen to attend the next one. (There are no records to indicate why the man had been refused permission to attend the earlier family day.) She also told the family links worker that the man had previously threatened suicide and had harmed himself when their relationship had been difficult.

43. On 11 March, the man was removed from the Storybook Dads course (where prisoners record themselves reading stories for their children) because he was reported to have been rude and disruptive in the class. He was notified of this in writing.

44. On 12 March, the family links worker sent an email to one of the prison chaplains, reflecting the concerns the man's partner had raised about him a week earlier. In her email to the chaplain, the family links worker said that the man's partner had said that he had threatened suicide if he was not able to live with her and their daughter when he was released. The family links worker asked the chaplain to speak to the man and check that he was okay. As a worker for an external agency, the family links worker did not have access to the prisoner record system and could not make an entry in the man's records to alert others. She did not share the information with anyone other than the chaplain.

45. The chaplain replied in an email to the family link worker later that day. He said that he had checked the man's case noted and did not have any concerns. He did not make any entry in the records himself and told the investigator that he could not recall speaking to the man directly at any point. The family link worker told the investigator, that she had understood, from a later conversation with the chaplain that he had been to speak to the man.

46. The man's partner told the investigator that she had spoken to a member of staff in the visits area on 19 March (she did not know the name of the person

she spoke to). The man's partner said that she had told an officer that she was concerned about the man as he did not seem to want to have anything to do with her or their baby. The man had a cut on his head and he had told her that he had been threatened in his cell by two prisoners and had been injured while defending himself. There is no evidence that the man reported this incident to staff or that staff took any action in response to what the man's partner had told them.

47. On 21 March, the man referred himself to the KAINOS programme (a six month offending behaviour programme). He was accepted for the programme, which was due to begin on 3 April.

48. The family link worker met the man's partner again on 26 March. They discussed some problems with postal orders. His partner said that the man had asked her to send postal orders to another prisoner so that he could buy tobacco for the man. She had done so, but they had since had an argument and she wanted the postal orders stopped and the money returned to her. The family link worker agreed to look into it for her. She recorded in her own notes about the man that she had submitted a security information report on the same day but we have not been able to find a copy of this.

49. A security information report, dated 29 March, noted that the man had told unit staff that another prisoner was bullying him and had been threatening him with a razor blade as he wanted a debt repaid. (It did not specify what the debt was for, but it seems to have been for tobacco.) Staff moved the other prisoner to a different unit but took no further action.

50. The officer wrote in the man's case notes on 29 March that he was worried that he had got into debt for tobacco. He said that the amount he owed had doubled over the previous three weeks and other prisoners were demanding that he get postal orders sent in for them to pay the debt. Staff moved the man to a single cell in Langdale Unit. Later that day, officers searched the cell and found part of a screwdriver and some items associated with drug taking. The man was charged with a disciplinary offence for possession of these items. (It was later accepted that the items had been left behind by the previous occupant of the cell and the charge was dismissed.)

51. On 2 April, the family link worker spoke to the man's partner again and told her that it was unlikely she could have the postal orders returned as she had sent them in freely. The man and his partner had been arguing at the time his partner asked for the postal orders to be returned and the family link worker considered that now that the argument was over, she was no longer concerned about them.

52. On 6 April, the family link worker saw the man who she said seemed "down and depressed" as he believed that social services would not allow him to live with his partner and baby when he was released. He talked about his relationship with his partner and said that he was worried that she would not be there for him when he was released. The family link worker suggested that the KAINOS course might help him prepare for release. By the end of their

meeting, the family link worker considered that the man's mood had improved and said he was smiling and talkative. On 16 April, the man's partner asked the family link worker to help the man apply to attend the next family day which the family link worker agreed to do.

53. During a telephone conversation on 4 May, the man told his brother that he was going to send him £100 and wanted him to transfer it to someone else's bank account. He did not say why and asked his brother not to mention this to anyone. (The £100 did not leave the man's account.) He spoke to his partner afterwards. They had a disagreement and ended the call abruptly. On 7 May, he spoke to his partner again and appeared to be on good terms.

54. The family link worker saw the man on 7 May, who said he was fine and had completed some of the KAINOS course, which he felt good about. They discussed his partner and baby. He said he found it difficult to trust people and did not think that his partner loved him. He said they had argued on the telephone and she had said "some nasty stuff". The family link worker said that people said things they did not mean during an argument. The man agreed and said they had sorted it out later. The family link worker noted that it was an "upbeat" meeting and that, although the man had been a little down when talking about his relationship problems, he had mostly appeared happy. The family link worker met the man's partner shortly afterwards who asked when the man would hear if he had been given permission to attend the family day. The family link worker did not know, as the prison chaplaincy arranged the family day.

55. The man telephoned his partner on 8 May and told her his application to attend the family day had been refused. He did not know the reason and was waiting for a written response. The man sounded very tearful during the call.

9 May 2014

56. The man had completed the first part of the KAINOS programme on 9 May and met his assessor to discuss his progress. The man said that he was enjoying the programme and understood its purpose. He said he had started to think a lot more deeply about issues. He told the assessor that his application to attend a family day had been rejected on security grounds and that he had lost his place on the Storybook Dads course because of negative behaviour. He said he would challenge these decisions. The man told the assessor that he wanted to develop his self- confidence, which had suffered badly as a result of a previous relationship. The man became tearful and said his lack of trust was affecting his current relationship. He had low self-esteem and felt low in mood. The assessor said she did not consider opening an ACCT at the time as she did not think that the man was at risk of suicide or self-harm.

57. Later that day, the man made two formal complaints. The first was about not being allowed to attend the family day. The man explained that the previous occupant had left the screwdriver and drug equipment in his cell. This had been accepted and the charge against him had been dismissed. However,

there was still a negative comment about this on his record and this had led to him being refused permission to attend the family day. The man asked for the comment to be removed and that his application should be reconsidered. The second complaint was about and about being removed from the Storybook Dads course, eight weeks earlier.

58. That afternoon the man went to collect his shop order but staff told him that they had not received an order form from him. The officer said the man seemed to accept this well and said he would submit one for the following week.

59. CCTV coverage of the man's unit on the afternoon of 9 May shows him coming in and out of his cell and interacting with other prisoners. At 4.14pm, he collected his evening meal. A little later, the man phoned his partner and they argued and swore at each other. They ended the call abruptly. The man called again and they continued to argue, although this time his partner asked him to ring the next day and the man agreed. At 4.40pm, the officer asked the man to finish his telephone call.

60. Another prisoner who was a friend of the man, said that he had lent the man some tobacco that afternoon. He was aware that the man had been arguing on the telephone, but said he had not seemed depressed and had been laughing and joking, the same as usual.

61. At 6.00pm, the officer unlocked the man's cell to give him a sandwich, which diabetics get for the evening. He said that the man had seemed fine and he had no concerns about him.

62. At 7.45pm, an officer carried out a roll check to see that all prisoners in the unit were present in their cells. The signature of the officer carrying out the check is illegible, but he or she did not note any concerns. A custodial manager, countersigned the check.

63. The prisoner in the cell next to the man, said that between 8.00pm and 8.15pm he heard a bang from the man's cell. Although it had made him jump, he thought nothing more about it at the time. Another prisoner in a nearby cell also said he had heard the noise.

64. At around 9.15pm, the night patrol officer did another roll check. When he got to the man's cell he could not see him or get a response from him. He thought that he might have been using the toilet and so continued the roll check and came back two minutes later. He tapped on the door observation panel and called to the man, but he still got no response. At approximately 9.20pm, the officer radioed a custodial manager, who was the night orderly officer in charge of the prison that night. The manager said he would come immediately. In the meantime, the officer continued to try to rouse the man.

65. The officer carried a sealed pouch with a cell key for use in an emergency at night, but he said he did not open the cell as he was locked on the unit on his

own. He could not see the man and did not consider it was safe to open the cell by himself.

66. The manager was in an office with two officers when he received the call from the officer on the unit. They all immediately went to the unit, which took about two to three minutes. They arrived at approximately 9.25pm. One officer went to look into the man's cell from the external window, but went to the wrong window and roused another prisoner. .

67. The manager and an officer went to the man's cell and could not see him through the observation panel. They opened the cell and found him hanging by a torn sheet attached to the toilet door frame. The officer cut the sheet, while the manager supported the man's body.

68. At approximately 9.29pm, the officer radioed a code blue emergency and requested an ambulance. An operational support grade in the control room, said she first needed the name of the prisoner and further information about his condition, otherwise the ambulance service would not send an ambulance. The control room called for an ambulance at 9.33pm. The officer ran into the unit when she heard the code blue. On the way to the cell, she collected an emergency bag and defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest)

69. The manager and the officer laid the man on the floor and noticed that part of the ligature was still around his neck. The manager removed this with his anti-ligature knife and saw that there was a deep laceration on the man's neck. The manager, who was a trained first-aider, checked the man for signs of life but could not detect any breathing, pulse or chest movements. He began to administer cardiopulmonary resuscitation. The officer then arrived with the emergency equipment.

70. The staff attached the defibrillator to the man, but it did not detect a shockable heart rhythm and the officer continued with chest compressions. The manager instructed the control room to arrange to open the internal prison gates to ensure that the ambulance could reach the houseblock quickly when it arrived. Paramedics arrived at the man's cell at 9.45pm and after continuing to administer cardiopulmonary resuscitation for a while, took the man to Barrow-in-Furness Hospital. They left the prison at 10.20pm. The paramedics noted that, because of the distance to the hospital and because they had had to stop twice to attend to the man urgently, it had been a long transfer to the hospital. Hospital staff continued emergency treatment, but a doctor pronounced the man dead at 11.31pm.

Support for staff

71. A debrief was held for staff involved in this emergency. The manager said that he was not satisfied that managers had supported staff appropriately and had raised the matter with the deputy governor. He said that, apart from requesting incident reports, no senior manager, except the chaplain, had spoken to the staff involved.

Support for prisoners

72. Prisoners the investigator spoke to said they generally felt supported after the man's death and staff offered them opportunity to speak to Listeners, Samaritans or the Chaplaincy. Staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by the man's death.

Family liaison

73. The prison informed the man's partner and his family about his death promptly and the family liaison officer and prison chaplain kept in regular contact.

74. The man's funeral was held on 22 May 2014. The prison contributed to the cost of the funeral, in line with national Prison Service guidelines.

Post- mortem

75. A post-mortem, carried out on 15 May, concluded that the man died as a result of hanging. A toxicology report recorded the presence of sertraline but not insulin. The sertraline was in line with a therapeutic range and played no part in the man's death.

Information received after the man's death

76. On 18 May, a man who had been released from Haverigg, informed the prison that the man had been under pressure for not repaying a debt to another prisoner. He thought that the man had owed £100 for spice.

77. Information from anonymous prisoners suggested that two prisoners, who the man owed money to for spice, had been threatening him. Another prisoner said that someone had taken his canteen sheet from him, which was why it was missing on 9 May. When the investigator met the man's partner, his partner said he had asked her to bring drugs in for him, so he could pay off his debts. She had refused. Other information suggested that the man had received a letter from an ex-partner, congratulating him on the birth of his child and had been upset about the letter

78. The prison found a letter dated 9 May which had not left in the prison, which the man had written to his partner apparently after he had spoken to her on the telephone. In the letter he spoke about the lack of trust between them and that they were obviously not right for each other. He signed off saying that he had always loved her, that he had not done anything wrong, but that he felt she would never believe him. The prison found another brief letter, dated 10 May (although he died on 9 May) in which he said that he had never lied to her and would not do anything to jeopardise their relationship. He signed the letter off with "Bye!!"

79. Another prisoner referred to the man in a letter to his own family. He said that the man was in a lot of debt and that he had lied and said that his mother had

died, in an attempt to get others to let him off some of the money he owed them.

ISSUES

Assessment of the man's risk of self-harm or suicide

80. There was information in the Person Escort Record and in the man's police custody record, which arrived with him at Preston, that he had taken an overdose four weeks earlier. There is no evidence that reception staff at Preston noted this, or took it into account when assessing the man's risk of suicide and self-harm.

81. On 29 October, HMP Preston received information from the man's doctor which described 'active problems' including two acts of deliberate self-harm but this did not lead anyone at Preston to review his risk. The information was recorded clearly in the man's medical record, but not picked up by staff at Haverigg. If they had read his medical record, it would have given them information about the man's history and informed risk assessments, including his suitability for in-possession medication.

82. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures and PSI 74/2011, about early days in custody, both list a number of risk factors and potential triggers for suicide and self-harm. The man had a number of these at the time of his reception into both prisons, including impulsiveness, low self-esteem, life events, relationship instability and lack of social support.

83. We accept that it might have been difficult to identify some of these factors, but staff should not have missed the fact that he had a history of self-harm, including a suicide attempt by overdose, just weeks before he arrived at Preston. The fact of his recent suicide attempt should have led staff to consider beginning Assessment, Care in Custody and Teamwork procedures, (ACCT - the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm). There is little evidence that staff took any of these factors into account when assessing his risk of suicide and self-harm and they appear to have taken the man's assertion that he had no thoughts of suicide or self-harm, at face value.

84. We cannot know whether the failure to consider whether the man needed the additional support of ACCT procedures when he arrived at either prison would have affected the eventual outcome, but there were also a number of other missed opportunities to record and share key information about the man's risk in the weeks before his death. These included identifying the risk associated with bullying and debt, his relationship difficulties, being removed from the Storybook Dads course, being refused permission to attend the family day and the information his partner gave the family links worker. The family link worker did not have access to prisoners' electronic prison records and was reliant on other staff recording information on her behalf, which does not appear to have happened. (The prison has told us that the family link worker is now able to use the system.) There was clearly some confusion between The family link worker and the chaplain as the family link worker believed that the chaplain had checked on the man, but this did not happen.

85. Staff judgement is fundamental to the suicide and self-harm prevention system, which relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. However, we are concerned that the staff relied so heavily on the man's assurances that he had no thoughts of killing himself when he arrived at both Preston and Haverigg, rather than making an assessment taking into account all his risk factors and the information available. It is concerning that no one at Preston acted on the information on the escort record about his recent suicide attempt. Subsequently, staff missed opportunities to speak to the man when further information came to light that might have increased his risk. We make the following recommendation to both Preston and Haverigg:

The Governor and Head of Healthcare should ensure that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

- **Have a clear understanding of their responsibilities and the need to record relevant information about risk in an appropriate manner.**
- **Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records.**
- **Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.**

Mental health assessment

86. In January, the doctor prescribed the man sertraline, an antidepressant. This should have given the mental health team some insight into his state of mind, but they were unaware of this. Although the doctor recorded this on SystmOne, it was not immediately obvious to other staff looking through the record. Clinical and mental health staff agreed when interviewed that communication between them was poor.

87. The reception nurse referred the man to the mental health team on 24 December, but a mental health nurse did not assess him until 12 February. The clinical reviewer considered that this mental health assessment was inadequate. It did not identify that the man's was taking a prescribed antidepressant and did not identify his previous suicide attempts. The assessment missed other indicators of risk, including his family and relationship issues. The nurse did not use a standard assessment tool to determine the man's risk and agreed during her interview that procedures at the time were poor and the assessment tools were not well used at the prison. We make the following recommendation:

The Head of Healthcare should ensure that mental health assessments are carried out promptly using a standard mental health assessment tool and take into account all relevant information.

Medication

88. The clinical reviewer noted that the doctor prescribed the man sertraline when he had said his mood was low. The doctor did not diagnose depression, although sertraline is usually prescribed for major depressive episodes. When interviewed, the doctor said that he had not thought that the man was clinically depressed at that time, but he had prescribed sertraline to ease his symptoms and because he believed that the mental health team would not be able to provide him with the appropriate support quickly.

89. The clinical reviewer also noted that sertraline has a known association with an increased risk of suicide, particularly in the under 25 age group. Because of the man's age and previous history, the clinical reviewer questioned the appropriateness of prescribing this medication. The doctor did not use any standard tools for assessing anxiety or depression as part of the man's medical assessment. NICE (National Institute of Clinical Excellence) guidelines suggest that patients who are prescribed antidepressants should be regularly monitored. People under the age of 30 who are considered to be at risk, should be seen one week after being prescribed the medication and then regularly afterwards. We are concerned that a doctor or member of the mental health team did not review the man's prescription of sertraline after he began to take it, We make the following recommendation:

The Head of Healthcare should implement standard depression screening and assessment and ensure, in line with NICE guidelines, that follow-up appointments are made to review the progress of prisoners prescribed antidepressants.

90. The man's family were concerned that toxicology results found no trace of insulin. The clinical reviewer noted that while it would be unusual for this not to be detected at all, it is possible that it had already been absorbed by his body at the time of the examination. He said that, even if the man had not been administering his insulin correctly, this should not have affected the man's mental health or caused him to have suicidal thoughts.

Bullying

91. In February, the man reported that he had been punched by a prisoner and staff began to monitor him using the prison's anti-bullying procedures. However, staff did not manage the process effectively, support the man appropriately, or investigate the allegations.

92. In July, the prison gave the investigator further information about the bullying allegations, which they had not provided at the beginning of the investigation. This included the identities of the prisoners who were believed to have been involved in threatening the man. The prison also provided evidence that the man had arranged for postal orders to be sent to another prisoner on 13 March and 21 March, which should have been investigated at the time.

93. It is evident from the information supplied that other prisoners were bullying and threatening the man, apparently because he had got into debt for drugs or tobacco. We consider that staff should have done more to investigate the circumstances and to protect the man. Prison staff knew the identity of the prisoners who were allegedly threatening the man yet no one challenged these prisoners, investigated the allegations against them or managed them under Haverigg's anti-bullying procedures.

94. A PPO publication of October 2011, 'Violence reduction, bullying and safety' noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages, and that these were more marked in young adults. In a recent learning lessons bulletin of July 2014, in which we looked at issues arising from the self-inflicted deaths of 18 to 24 year old prisoners, we found that 20% of prisoners in our sample had experienced bullying from other prisoners in the month before their death, compared to 13% of other prisoners. We are concerned that none of the staff who dealt with the man appeared to consider whether his fears about his safety might have increased his risk of suicide and self-harm. We make the following recommendation:

The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that victims are effectively supported and protected and the possible impact on their risk of suicide and self-harm is considered.

Family Day

95. The man was upset that he had not yet met his new born daughter. He had been looking forward to attending the prison's family day, due to be held later in May, when he would have been able to spend time with his partner and their child. Prison staff refused his application to attend the family day on security grounds. This was because incorrect information about an alleged disciplinary offence for possession of unauthorised articles had remained on the man's record after staff had accepted that the articles had belonged to the former occupant of the cell. The man was distressed about the decision, which he received the day before his death. It is important that prison staff use accurate and up to date information when taking decisions about prisoners, particularly those which are likely to affect their wellbeing. We make the following recommendation:

The Governor should ensure that prison staff use accurate and up to date information when making decisions about prisoners.

Emergency response

96. At night, staff on wings do not carry standard keys, but have a cell key in a sealed pouch for use in an emergency. National instructions in PSI 24/2011 say that staff have a duty of care to prisoners, to themselves and to other staff. While they are expected to put the preservation of life ahead of usual arrangements for opening cells, they are not expected to take action that they

consider would put themselves or others in unnecessary danger and should first make every effort to get a verbal response from the prisoner. When the chaplain could get no response from the man he had no reason to believe that he was hanging and we are satisfied that it was reasonable for him to wait for help rather than going into the cell alone,

97. However, we are concerned that there was a four minute delay before control room staff called an emergency ambulance. Prison Service Instruction (PSI)3/2013 requires governors to have a medical emergency response code protocol to ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. Haverigg has a protocol with the local ambulance services, in line with the national instruction which makes it clear that staff should call an ambulance immediately and should not wait for additional information before doing so. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance as soon as they receive an emergency code blue call.

RECOMMENDATIONS

To HMP Preston and HMP Haverigg:

1. The Governor and Head of Healthcare should ensure that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

    - Have a clear understanding of their responsibilities and the need to record relevant information about risk in an appropriate manner
    - Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records
    - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.

To HMP Haverigg:

2. The Head of Healthcare should ensure that mental health assessments are carried out promptly using a standard mental health assessment tool and take into account all relevant information.

3. The Head of Healthcare should implement standard depression screening and assessment and ensure, in line with NICE guidelines, that follow-up appointments are made to review the progress of prisoners prescribed antidepressants.

4. The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that victims are effectively supported and protected and the possible impact on their risk of suicide and self-harm is considered.

5. The Governor should ensure that prison staff use accurate and up to date information when making decisions about prisoners.

6. The Governor should ensure that control room staff call an ambulance as soon as they receive an emergency code blue call.

ACTION PLAN

No	Recommendation	Accepted /Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should: Have a clear understanding of their responsibilities and the need to record relevant information about risk in an appropriate manner Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.	Accepted	All staff that manage prisoners on Assessment, Care in Custody, and Teamwork documentation (ACCT) will be identified and must complete the Introduction to Safer Custody course. This incorporates the requirements in point 1. All managers that are responsible for managing ACCT prisoners will ensure that they have completed the Case Management training before the end of the current Staff Performance and Development Record (SPDR) period. This will be recorded in the SPDR developments field. The Safer Custody committee will discuss and analyse reports from the quick time learning bulletins and compare with current local practice. Deficiencies to be cascaded to staff via the Safer Custody manager. A safer custody checklist will be reintroduced to the first night process to ensure that physical checks of prisoner records is conducted to identify the elements of point 2. The Safer Custody manager will quality check (Weekly) observation books and Incident Reporting System (IRS) to identify whether an ACCT document was appropriate and if appropriate, if done. The Safer Custody manager	Safer Custody manager, line-managers and Detail manager. Ongoing training to be completed by 31st March 2015. Safer Custody manager and the Prisoner Induction Custody Manager to implement by 31st December 2014. Safer Custody manager will ensure that this process starts immediately. First report	

			will report the findings to the manager involved and ensure that any failure is addressed immediately.	to the Safer Custody committee for November meeting.	
2	The Head of Healthcare should ensure that mental health assessments are carried out promptly using a standard mental health assessment tool and take into account all relevant information.	Accepted	Agency staff and permanent staff appointed were appointed week commencing 17/11/14. Since 25 November 2014 there has been the capacity to undertake this. Mental health documentation , care planning and risk assessment are on the mental health clinical tree of SYSTM1, but as part of the pathway working group will be re-visited to ensure they are appropriate and comprehensive Meetings are in place with the Safer Custody manager, who is now attending clinical governance meeting, and complex clients meeting. All staff have been alerted to need to reference both paper and electronic record, when working with clients.	MHT Immediately MHT Immediately SC Manager Immediately MHT Immediately	
3	The Head of Healthcare should implement standard depression screening and assessment and ensure, in line with NICE guidelines, that follow-up appointments are made to review the progress of prisoners prescribed antidepressants.	Accepted	An anti-depressant pathway is being developed and has been available in draft form since the end of November 2014. The principle being that all clients on anti-depressants will be assessed with a number of the less complex clients being managed by G.P services, the more complex clients being managed by the in-reach team All mental health tasks will be reviewed within 24 hours working hours	Mental Health Team 1st January 2015	

			Those that are via triage felt appropriate for mental health services will be assessed within 72 working hours The Mental Health Team are aware of the guidelines for under 25's with depression and this will be built into pathways as discussed in previous bullet point There will be Mental Health drop in room on all wings. The availability of an appropriate room on R1 and R5 will be identified to complete this task. The Mental Health Team will ensure alerts are in place for those clients they are aware of, but in some instances ACCTS are opened where there is no indication of mental health issues. in these cases the responsibility for placing alerts on the home page lays with the person who opened the ACCT.		
4	The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that victims are effectively supported and protected and the possible impact on their risk of suicide and self-harm is considered	Accepted	The Safer Custody manager will quality check all Tackling Anti-social Behaviour (TAB) documents at least weekly. The findings will be added to the local Incident Investigation Log and reported to the Safer Custody committee. The Head of Residence & Safety will discuss the failings with the manager involved. The Safer Custody manager will review the use of the local interventions directory and the levels of interventions available to both Victims and Perpetrators. This will be incorporated into the TAB/IEP documentation. (Incentives & Earned Privilege)	Safer Custody manager to commence immediately. The Head of Residence & Safety will discuss with managers on receipt of report. Safer Custody manager 31st December 2014.	
5	The Governor should ensure that prison staff use accurate and up to date information when making decisions about prisoners.	Accepted	A notice to staff (NTS) will be published to ensure that all staff are reminded about what needs to be considered when making decisions that affect a prisoner or when opening and managing an ACCT	Head of Residence & Safety 30th November 2014.	

			document. A risk assessment template will be completed when any prisoner moves to a new location within the prison.	Custodial Manager of R3 Unit 31st December 2014.	
6	The Governor should ensure that control room staff call an ambulance as soon as they receive an emergency code blue call.	Accepted	A NTS will be produced to inform all staff and specifically control room staff and First on Scene staff as to the required response to Code Blue calls.	Governing Governor and Head of Residence & Safety 31st December 2014.	