A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in January 2015 at HMP Hull

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Hull in January 2015. He was 28 years old. I offer my condolences to his family.

A clinical review of the care the man received at Hull was undertaken. Hull co-operated fully with the investigation.

The man was from Bangladesh and had been charged with murdering his brother, an Imam. He spoke and understood very little English. However, when he arrived at Hull on 24 October 2014, reception staff did not use an interpreting service. A few days after he arrived at Hull, he became distressed. Officers began suicide and self-harm prevention procedures, but again did not use official interpreting services and relied on another prisoner. Members of the chaplaincy team attended case reviews, but healthcare staff did not. His mood appeared to improve, and a manager ended the monitoring in November.

The prisoner who had previously interpreted for the man was released in December and he appeared isolated and withdrawn. He began to neglect his personal hygiene. In January, officers asked the prison Imam to speak to him about this, although he also had difficulty communicating with him, as he did not speak Bangla. Four days later, a night patrol officer found him hanged in his cell.

I am concerned that reception and nursing staff did not identify factors which increased the man's risk of suicide and self-harm when he arrived at Hull. This was his first time in prison, he was accused of murdering a close relative and spoke very little English. Despite the serious charge he was facing and his reported depression, he was not referred for a mental health assessment when he arrived. I am seriously concerned that staff consistently failed to use the official interpretation service to speak to him. It is difficult to understand how staff at the prison could have made an informed decision about his risk in these circumstances. Although, it would not have altered the outcome for him, after being alerted to the emergency, it took too long for a nurse to reach his cell and before staff called an ambulance.

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 **September 2015**
Prisons and Probation Ombudsman

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SUMMARY

1. The man was charged with the murder of his brother, an Imam, and remanded to HMP Hull on 24 October 2014. He was a citizen of Bangladesh, and had very limited English. Despite this, no one in reception at Hull, including nurses who completed an in-depth physical health screen, used a telephone interpreting service to help assess him. He was charged with a serious violent offence against a family member and was in prison for the first time but no one identified him as at risk of suicide and self-harm. He was not referred for a mental health assessment.

2. On 27 October, the man told another Bangladeshi prisoner that he had thoughts of hanging himself. The prisoner told the wing staff and, they began Prison Service suicide and self-harm prevention procedures, known as ACCT.

3. Staff held three ACCT case reviews over the next two weeks, none of which had a member of healthcare staff present. The other Bangladeshi prisoner attended to interpret for the man. At the first and second case reviews, he said that he wanted to kill himself, but staff assessed his risk of suicide and self-harm as low. On 10 November, at a third review, staff ended ACCT monitoring as they thought that his mood had improved. Staff recorded little information about him after the ACCT was closed, although they noted he was withdrawn and neglected his personal hygiene.

4. In January, a night patrol officer found that the man had hanged himself using torn bedding, attached to the cell window. He radioed an emergency code, went into the cell and cut the ligature. The control room did not call an ambulance until 14 minutes later. The staff did not attempt resuscitation, as it was apparent that he had been dead for some time. Paramedics arrived and confirmed death.

5. We are concerned that prison staff did not use professional interpreting services when assessing the man when he arrived or for other important and confidential matter such as ACCT reviews. Communication problems caused him to feel isolated, but staff did not refer him for English classes. When he was supported using ACCT procedures, no member of the healthcare team was involved at any stage, risk assessments were poor and caremap actions were not completed. He never had a mental health assessment. Although it would not have affected the outcome for him, there was an unacceptable delay in calling an ambulance and we are concerned that a nurse had to wait to be collected by an officer, which meant she did not reach his cell for at least nine minutes after he was found. We make seven recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at Hull informing them of the investigation and inviting anyone with relevant information to contact him. An ex-prisoner, who said he had been on the same residential unit as the man responded. He said he would write a statement about his knowledge of him, but we have not received one.

7. The investigator visited Hull on 29 January and obtained copies of the man's clinical and prison records.

8. NHS England commissioned a clinical reviewer to review the man's clinical care at Hull.

9. The investigator informed HM Coroner for Kingston upon Hull of the investigation, who provided the results of the post-mortem examination. We have sent a copy of this report to the coroner.

10. One of our family liaison officers contacted the man's family to explain the investigation process. They asked for more information about his remand status, his physical and mental healthcare and whether he was prescribed any medication. They wanted to know the exact circumstances of his death and whether he had left a note explaining his actions.

11. The family received a copy of the draft report. They did not raise any further issues, or comment on the factual accuracy of the report.

HMP HULL

12. HMP Hull is a local prison, which holds approximately 1,000 unconvicted and sentenced men across ten residential wings.

HM Inspectorate of Prisons

13. HM Inspectorate of Prisons (HMIP) last inspected Hull in October 2014. At the time of the inspection, foreign national prisoners made up around 6% of the prison population. Prison staff told inspectors that that telephone interpreting services were used in reception only as a last resort. Inspectors noted some limited use of telephone-interpreting services in the three months prior to their inspection, but were concerned that staff did not use professional interpreting services for all important, sensitive, or confidential matters. Inspectors considered that lessons from our investigations into previous deaths in the prison had been implemented, but found that ACCT case management documents for prisoners at risk of suicide or self-harm varied in quality. Prisoners subject to ACCT procedures were negative about the support they received from staff, but were positive about the help they received from prisoner peer support workers.

Previous deaths at Hull

14. The man's death was the first self-inflicted death at Hull since 2011. In the investigation report after that death, we made recommendations about the management of suicide and self-harm prevention procedures and emergency response procedures. Similar issues arose in this investigation.

Assessment, Care in Custody and Teamwork

15. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary review meetings involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 4/2011.

KEY EVENTS

16. On 24 October 2014, the man was remanded to HMP Hull, charged with the murder of his brother, who was an Imam and described as a prominent Islamic scholar. He was from Bangladesh. He had no previous convictions in the United Kingdom. He could not read or write English and could only speak a few words in English.

17. The police had noted on the man's Person Escort Record (PER), a document which accompanies all prisoners when they transfer between police stations, courts, and prisons, that they had used a Bangla interpreter when they interviewed him. Escort staff passed the PER to reception staff at Hull.

18. A nurse assessed the man when he arrived at Hull. She noted in the medical record that he had been accused of murdering his brother and had said that he suffered from stress and depression. She recorded that he reported no concerns about his physical health, but said that he had been taking medication for depression. She recorded that he could not communicate effectively enough for her to record what the medication was. (She noted on his medical record that he spoke Vietnamese and appeared to be struggling with the language barrier.)

19. The nurse recorded that the man was tearful about his situation and found it difficult to communicate, but recorded that he appeared mentally stable, made good eye contact and said that he had no thoughts of suicide and self-harm. She no longer works at Hull and did not respond when we asked to interview her. However, there is no evidence that she used an interpreting service during her assessment, or had anyone to interpret for her. She did not refer him for a mental health assessment. There is no record of any further assessment in reception.

20. The officer who completed a first night induction with the man in the prison's induction unit, said that his aim is to process prisoners quickly so they can settle in. Staff are required to complete a number of forms with new prisoners, which give information about rules and prison procedures, and prisoners are expected to sign to indicate they understand them. The forms are available in some languages other than English, but not Bangla. He told the investigator that the man must have had a limited amount of English for them to have completed the documentation. He said that he could use a telephone interpreting service but had not done so with him. He did not consider that the man needed to be supported by ACCT suicide and self-harm prevention procedures.

21. The man was given a single cell in the prison's induction unit. The next day, 25 October, a nurse completed a second day health screen. He noted that the man raised no concerns, maintained good eye contact, was able to answer questions clearly and did not report any thoughts of

suicide or self-harm. The nurse completed the healthcare section of the Cell Sharing Risk assessment (CSRA), and indicated that the man was a standard risk, and could share a cell if required.

22. The nurse did not use an interpreter, and told the investigator that he was not aware of the interpreting service. He said that he usually communicated with prisoners with little English using a combination of Google Translate, hand gestures and Pidgin English. The nurse had recorded that the man was taking medication for depression, but neither he nor the officer referred him to the mental health team.

23. Later that morning, a member of the prison chaplaincy team visited the man as part of the routine for new prisoners. She said that he was pacing up and down his cell. She said that she introduced herself and asked him about his religious beliefs. She said that she did not use an interpreter and felt that he understood her. She said that he told her that he believed in Allah, but hated Islam and Muslims.

24. The chaplain told the investigator that she relied heavily on hand gestures to communicate with the man. She said that he used only two or three words in his answers. She reported his comments about hating Muslims to the wing manager, a Supervising Officer (SO). The SO reviewed his cell sharing risk assessment and noted that he was unsuitable to share a cell.

25. On 27 October, another Bangladeshi prisoner told an officer that the man had said that he wanted to die. The officer was concerned that he was isolated, not communicating and had not collected meals, so he began ACCT suicide and self-harm prevention procedures.

26. The SO completed an ACCT immediate action plan, and set the level of observations as frequent, but did not specify what this meant. Staff were required to make one meaningful entry in the ACCT document morning, afternoon and evening. He then assessed the man as part of the ACCT process and used the Bangladeshi prisoner to interpret. The SO recorded that the man was tearful and said that he was depressed and had not committed the offence he was charged with. He said that he had previously taken an overdose. The man said he felt unwell and wanted staff to kill him. He said that he thought about suicide but did not want to do it himself.

27. The SO said he had asked the man if he wanted him to use the Bangladeshi prisoner or a telephone interpreting facility, and that he had indicated he would rather have the prisoner. It is not clear how he communicated this. The SO said that he had used the telephone interpreting service for ACCT assessments in the past and said that this could be very difficult because of the number of questions he needed to ask. At the assessment, he noted that the man was tearful, low in mood and had a history of self-harm.

28. The SO then attended an ACCT case review with two other supervising officers and a chaplain. There was no member of the healthcare team present, although this is a mandatory requirement for first ACCT case reviews. The Bangladeshi prisoner was present to translate for the man. The SO said that he asked the prisoner to reassure him that he was safe and that he should try to come out of his cell more. He arranged for him to move to the ground floor landing to be nearer the prisoner. Although he had told the SO during the assessment that he wanted to die and had thoughts of suicide, the case review recorded his risk of suicide and self-harm as low. The review agreed one action for the caremap (which is designed to address main concerns and should include actions to reduce risk). This was for staff and the prisoner to help him address his feelings of isolation. It did not specify any specific actions setting out how this would be achieved. Another SO set the next review for 3 November, and noted that the prisoner should be invited.

29. On 29 October, the man had an appointment with a GP. The reason for the appointment is not clear and the GP recorded on the medical record 'poor English skills, no interpreter available'. The GP said that he did not see him, had no further contact with him and could add no more.

30. That morning, prisoners from the induction wing were taken for education assessments, which are used to determine prisoners' levels of literacy and allocate them to appropriate education classes. The man missed the assessment as he had been taken to the GP appointment. Induction staff said that when prisoners miss these assessments they normally attend the next available session. However, he did not have this education induction until 21 January 2015, three months after he had arrived at Hull. After he completed the rest of his induction, he moved to C Wing with the Bangladeshi prisoner, as they were close. The prisoner continued to help him communicate with staff.

31. On 3 November, a SO held the second ACCT case review. (The SO told the investigator that, although he had been trained as an ACCT assessor, he had not been trained as a case manager.) Another supervising officer and a member of the chaplaincy team attended. The SO did not record whether the Bangladeshi prisoner was present to interpret for him, but said he was sure he would have been.

32. The SO recorded that the man was still finding prison life difficult and said that he had thought about killing himself. Despite this, the staff assessed his risk of suicide and self-harm as low. Staff were required to observe him hourly during patrol states (periods during the day when prisoners are locked in their cells, such as at lunchtime) and hourly at night. They were also expected to make a detailed entry in the ACCT document at least three times during the day. Despite his previous comments about hating Islam and Muslims, the SO added a second

action to the caremap, for him to attend Friday prayers. It is not clear whether he agreed this with him.

33. Staff often recorded in the ACCT document that, when they observed the man, he either nodded his head or put his thumb up, to indicate that he was all right. An officer told the investigator that when he had opened the ACCT, he had asked the Bangladeshi prisoner to explain to the man that staff would check on him, and that if he was all right, he should signal with a 'thumbs up' and, if not, then a 'thumbs down.' This continued while he remained on the ACCT.

34. On 5 November, wing staff asked the prison Imam to speak to the man, as they could not communicate with him and thought he was isolating himself on the wing. The Imam said that the staff had told him that the man was not leaving his cell or collecting his meals. He said that he asked him how he was feeling but he had indicated that he did not speak English. The Imam said that he does not speak Bangla, but spoke to him in Hindi, which he understood a little. The Imam invited and encouraged him to attend Friday prayers and have him a prayer timetable. He said that he was aware that it had been reported that the man hated Muslims, but he did not consider that he was a risk. He thought that the man had been concerned that other Muslim prisoners might target him, because his brother had been an Imam.

35. On 6 November, the man attended an appointment with a prison GP. The GP could not remember what had prompted the appointment. He said that the man was feeling low and unable to communicate, although he said there was another prisoner who he could speak to. He said that the man used a few words of English, but they mainly communicated using limited Hindi and Bangla. He said he asked about the medication the man had taken in the community. He offered to prescribe medication to help improve his mood but he said that he did not want to take anything. He said that officers did not usually bring ACCT documents to medical appointments and he was unable to record anything in the ACCT record.

36. On 10 November, a SO held a third ACCT case review with another SO and a member of the chaplaincy team. The Bangladeshi prisoner interpreted for the man. At the review, the staff decided to close the ACCT as they thought that he had settled quite well in prison and was no longer thinking about harming himself. The SO Miller told the investigator that, by then, he was coming out of his cell and mixing with other prisoners. He said that it was also evident that he had started looking after his physical appearance, which he had not done previously.

37. In the record of the review, the SO noted that he had told the man that he would not be allowed to attend Friday prayers because of the comments he had made about hating Muslims and also noted this on the caremap. Neither actions on the caremap were marked as

completed. The SO said that the man was unhappy about not being able to attend prayers, but seemed to accept it. The SO said that this restriction was lifted later and the man began attending Friday prayers. The Imam told the investigator that the man began to attend prayers, but we have not been able to establish when this was. The SO set a post-closure review for 17 November.

38. On 12 November, the Bangladeshi prisoner asked a mental health nurse if she would speak to the man as he was unable to sleep and had spent the previous three nights crying. She said that when she went to see him, with the prisoner, he did not appear distressed and was watching television in his cell. She said that she asked him if he wanted to speak to her or see a doctor about being unable to sleep. Initially, he said that he did not want to see anyone, but then agreed that she to refer him to the primary care mental health team.

39. The next day, the mental health team sent an appointment slip to the man on 13 November, informing him of an appointment on 5 December. The appointment slip was returned the same day, indicating that he no longer wanted the appointment. (It is not clear who completed the form, which is in English.) The mental health nurse told the investigator that if a prisoner declined an appointment, staff would not normally follow this up, as it was their decision.

40. On 14 November, an officer noted in the man's prison record that he had asked to go to Muslim prayers, but she had told him he was not allowed because of his comments about hating Muslims. The Imam saw him the same day, and the man told him that he had researched several religions, and had now chosen Islam.

41. A SO held an ACCT post-closure review with the man on 21 November (outside the expected one week review period). The SO noted that he felt more settled, and that he had the support of other Bangladeshi prisoners and his family. There is no record that anyone interpreted for the SO and the man. The SO did not re-open the ACCT.

42. Staff recorded no significant information about the man for the remainder of November and December. On 12 December, the Bangladeshi prisoner was released from prison.

43. On 21 January, the man completed education assessments, which identified that he had only a limited ability to speak or understand English. Education staff placed him on a register to await allocation to suitable classes.

44. That day, wing staff asked the Imam to speak to the man, as he was not showering, his cell was dirty and they were unable to communicate with him. The Imam said that he was sitting on his bed reading when he went to his cell, which was how he spent most of his time. He said

that the smell in the cell was quite bad and he asked wing cleaners, who were outside the cell, to clean the floor.

45. The Imam said that he told the man that cleanliness was part of his faith and encouraged him to shower and attend Friday prayers, which he agreed to do. However, he did not attend prayers on 23 January. The Imam had no further contact with him.

46. On Saturday 24 January, an operational support grade (OSG) was the night patrol officer on C Wing. During the night, he carried out ACCT checks, but had no reason to check the man and did not go to his cell during the night.

47. At approximately 5.21am, the OSG began a check to ensure that all prisoners were accounted for and in their cells. When he reached the man's cell, he saw him had hanged himself by a piece of torn bedding attached to the window bar. He radioed a code blue emergency. (A code blue is used in a medical emergency to indicate a life-threatening situation such as when a prisoner is unconscious or not breathing. It should alert staff to attend with emergency equipment and result in the control room calling an ambulance immediately.)

48. For security reasons, prison staff on wings at night do not carry standard prison keys, but have a cell key in a sealed pouch for use in an emergency. The OSG used the emergency key and went into the cell. He cut the ligature and placed the man on the floor. He said that the man felt cold and his limbs were stiff.

49. The custodial manager in charge of the prison that night said that he was in the prison gate area when, at 5.26am, the control room contacted him to ask if he had heard the code blue. He had not heard the emergency code and told them that he would go to C Wing immediately.

50. The custodial manager said that he arrived at the man's cell at around 5.30am, just after other staff. He asked whether anyone had attempted cardiopulmonary resuscitation but the OSG told him it was too late. The custodial manager said it was evident from his appearance that he had been dead for some time.

51. The custodial manager phoned an officer in the control room and asked him to contact the duty governor and call an ambulance. As he did, a nurse arrived and assessed the man. She told us that she had had to wait for an officer to come to escort her from the healthcare centre as she did not have keys to pass through the prison. She estimated that she arrived on the wing at 5.30am. She recorded that there was no entry to the man's airway because of swelling, his body was cold and his limbs were stiff. She told the custodial manager that, in her opinion, he had been dead for some time.

52. The officer told the investigator that he had logged the code blue call from the OSG at 5.21am and then immediately radioed the nurse and custodial manager. He was unaware that he was expected to call an ambulance as soon as he received a code blue and did not call one until 5.35am, when the custodial manager asked for one. This was 14 minutes after the initial code blue. The ambulance service told him they had an ambulance nearby and he said that it arrived while he was still on the phone.

53. Paramedics arrived on the wing at 5.40am and at 5.41am, confirmed death

Actions after the man's death

54. Staff involved in the emergency response attended a debrief and the staff care team offered support. Members of the prison chaplaincy team supported prisoners on C Wing.

55. A family liaison officer was appointed. The man had named one of his brothers as his next of kin. Because there was an ongoing criminal investigation, which had directly involved his family, she contacted the police family liaison officer. They agreed that the police family liaison officer would inform his family of his death. However, the police discovered that the man's brother was in Bangladesh. The prison contacted him and let him know what had happened. The prison remained in contact with the brother and other family members and offered assistance with funeral costs in line with national guidance.

Post-mortem

56. A post-mortem examination found that the man had died from hanging.

ISSUES

Communication with prisoners who speak little or no English

57. Prison Service Instruction (PSI) 64/2011, which gives instructions to staff about safer custody, states:

> ‘All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and / or during the risk management process.’

58. The Prison Service’s policy on foreign national prisoners states:

> ‘Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline.’

59. It was evident that the man spoke and understood little English. The police noted that he had needed a Bangla interpreter while he was in their custody. Hull has a contract with a professional telephone interpreting service, yet when he arrived at the prison in October 2014, reception staff did not use the service and there is no record that they used anyone else to interpret for them. It seems highly unlikely that he would have been able to understand their questions sufficiently well for reception staff to make reliable assessments of his health, state of mind or risk of suicide and self-harm.

60. We checked with the prison’s finance department and established that, in the last quarter of 2014, Hull did not receive any invoice for the use of the telephone interpreting service, which indicates that staff did not use it to communicate with any prisoner. We consider it unlikely that all of the foreign national prisoners who passed through Hull in that time spoke and understood English well enough not to need an interpreter. There were 65 foreign national prisoners in Hull in October, 58 in November and 54 in December. Although there is no record of their proficiency in English, the fact that there is an active English as a second language course suggests that a number of foreign national prisoners are not proficient in English when they arrive. HMI Prisons was also concerned about the lack of use of interpreting services when they inspected the prison in October 2014, while the man was there.

61. The clinical reviewer found that the level of health care the man received was not equivalent to that he could have expected in the community, primarily because of the lack of effective communication with him in a language he could understand. We are concerned that

reception staff did not adequately assess his level of risk, partly because they could not communicate with him.

62. Although using another prisoner to interpret is adequate for day-to-day needs on a wing, we do not consider it appropriate to use another prisoner to interpret during ACCT case reviews. Staff cannot be certain that the prisoner at risk is content to use another prisoner. Even if willing, they should not be required to disclose sensitive confidential information in front of another prisoner, but most will not be aware they have any other choice. The lack of use of the telephone interpreting service at Hull is a concern, as accurate and effective communication with prisoners with health problems or who are at risk of suicide or self-harm is vital. We make the following recommendation:

The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

63. As part of his induction, the man should have seen a member of the education department for an assessment. However, he attended a healthcare appointment that day (although he was not seen) and missed the assessment. After that, he was not assessed or referred directly for English classes for another three months, despite his obvious communication problems. We consider that he should have received help to improve his English much earlier. This might have helped him to adapt to prison life, interact with prisoners and staff better and give him some useful occupation to distract him. We make the following recommendation:

The Governor should ensure that foreign national prisoners who do not speak or understand English well are referred promptly for English classes.

Managing the risk of suicide and self-harm

64. As noted, a nurse and an officer did not use an interpreter to speak to the man when he arrived. This did not help effective assessment of his risk of suicide and self-harm. However, they did not need to speak to him, or use the available information, to establish that he had a number of risk factors for suicide and self-harm. He had been charged with a violent offence against a family member, (the murder of his brother, a respected Imam), this was his first time in prison and he was a foreign national.

65. In a PPO thematic report on the risk factors which increase the risk of suicide and self-harm, published in April 2014, we identified these and other risk factors that staff need to take into account when assessing

the risk of suicide and self-harm. They are also set out in Prison Service instructions to staff. There is no record that any member of staff considered the risk factors that applied to the man. We make the following recommendation:

The Governor should ensure that reception staff consider and record all the known risk factors of a newly-arrived prisoner when determining risk of suicide or self-harm including information from prisoner escort records and previous prison records.

66. An officer opened an ACCT after another prisoner was concerned about him and told the officer that the man had said he wanted to die. This was the correct action for the officer to follow. However we have concerns about how effectively staff implemented ACCT procedures to support the man. As noted, no one used an official interpreter. We are also concerned that no member of the healthcare team attended any case reviews, including the first review, which is a mandatory action in national instructions.

67. We are also concerned about the adequacy of risk assessments at ACCT reviews. At the first and second case reviews, officers assessed the man's risk as low, even though he had said that he had thought about taking his own life. A SO, who said he had not been trained as an ACCT case manager, told the investigator that he had assessed the man's risk as low because he appeared to be engaging with the Bangladeshi prisoner and had not harmed himself. We consider that officers should have given more weight to what he said and his known risk factors for suicide and self-harm, rather than how he was presenting.

68. Staff did not adequately address the man's risks and needs through a fully effective ACCT caremap. The first recorded issue was language and social isolation. No specific member of staff was identified to resolve the issue, which was largely left to another prisoner. No consideration was given to helping him address his isolation by improving his English. There was no consideration of what might happen if the prisoner left. There was an action for him to engage with others, by attending Muslim prayers. This was not possible because of he had made comments about hating Muslims and was not allowed to attend. There is no evidence this was recognised and discussed at the ACCT case reviews and no one considered an alternative action to help him engage with others. Staff closed the ACCT document and ended monitoring, although neither of these caremap issues had been resolved or the actions achieved.

69. Officers relied on hand signals to check the man's wellbeing. The ACCT document indicated that staff should make at least three meaningful entries in the document during the core day and conduct hourly observations at night or during patrol states. (Patrol state usually means when a wing is locked down with minimal staff, but

logically, this should have required staff to observe him hourly whenever he was confined to his cell.) He did not have a job at Hull, so he spent the majority of his time in cell. Staff did not conduct hourly observations at these times.

70. We are not satisfied that staff used ACCT procedures fully effectively to support the man. We make the following recommendation:

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

- **Considering all known risk factors when determining the level of risk of suicide and self-harm.**
- **Holding multidisciplinary case reviews chaired by trained staff, which include all relevant people involved in a prisoner's care.**
- **Ensuring that healthcare staff attend the first case review and inviting contributions from healthcare staff if they cannot attend subsequent reviews.**
- **Setting ACCT caremap actions that are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them.**
- **Ensuring that all caremap actions have been completed before the ACCT is closed.**

Mental health assessment

71. The lack of healthcare input into the ACCT process was particularly concerning, as no one referred the man for a mental health assessment, when he arrived at the prison, even though he had been charged with the murder of his brother and reported suffering from stress and depression. Before the introduction of the electronic prison medical record it was a mandatory requirement for all prisoners charged with 'domestic' homicide to be referred for a mental health assessment. When we asked previously, why this requirement had been removed, the National Offender Management Service (NOMS) was unable to explain why. In a previous case of a death in 2011, we made a national recommendation about this. NOMS accepted the recommendation 'in principle', subject to resources being available.

72. A referral for a mental health assessment, even when prisoners are not displaying overt mental health problems, for prisoners charged with killing a family member, can act as an important safeguard. The impact of guilt, bereavement and the potential complications of contact with the rest of the family may well have an effect on a prisoner's mental health. The man had been charged with the murder of his brother, a respected Imam, and was evidently anxious about how others would view this. We are unaware of any specific resource restrictions that would have prevented a mental health assessment in

this case and we consider this should have been done when he first arrived at the prison. We note that he apparently declined a mental health assessment later in November. However, the lack of adequate communication in a language he understood, gives us no reassurance that this was an informed decision. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners charged with homicide against a family member are referred for a mental health assessment.

Emergency response

73. It is clear that the man had been dead for some time when he was found. The OSG said that his body was rigid and a nurse noted that his skin was mottled and his body was stiff. These are recognised signs of death and we consider that staff acted appropriately in not attempting to resuscitate him. However, there was a fourteen minute delay between staff discovering him and the control room calling an ambulance. Although he had already died, the control room staff were unaware of this and in other emergencies such a delay could be critical.

74. Prison Service Instruction (PSI) 03/2013 requires all prisons to have an emergency code system to effectively communicate the nature of an emergency and ensure there is no delay in calling an ambulance. The instruction states that when a medical emergency is called, the control room should call an ambulance immediately. Hull issued guidance about this issue to staff in February 2013, but a custodial manager and an officer said that they were unaware of these "new" instructions. It is particularly concerning that the manager responsible for the security of the prison and the safety of prisoners should be unaware of this. The fact that the control room officer responsible for calling an ambulance also did not know about the instruction, suggests that the prison need to make sure that all staff understand what to do in an emergency. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and ensures the control room calls an ambulance immediately an emergency code is used.

75. We are also concerned that the nurse had to wait for an officer to collect her from the healthcare unit as she did not have keys to move through the prison at might. This meant that she did not arrive at the man's cell until at least nine minutes after the OSG found him. We have previously made recommendations to other prisons where nurses had to wait to be collected, and they have amended their security policy to make sure that nurses have easier access to the rest of the prison at night. Staff discussed the delay in the nurse reaching the cell

at the hot debrief held after his death. However, we are aware that, following another death at Hull in February 2015, a nurse was delayed getting to a cell for at least five minutes.

76. We consider the prison should do everything it can to ensure that the preservation of life is placed over security concerns. The current arrangements mean there is an inherent and unacceptable delay in healthcare staff reaching a prisoner in an emergency at night. We make the following recommendation:

The Governor should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

2. The Governor should ensure that foreign national prisoners who do not speak or understand English well are referred promptly for English classes.

3. The Governor should ensure that reception staff consider and record all the known risk factors of a newly-arrived prisoner when determining risk of suicide or self-harm including information from prisoner escort records and previous prison records.

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

   - Considering all known risk factors when determining the level of risk of suicide and self-harm.
   - Holding multidisciplinary case reviews chaired by trained staff, which include all relevant people involved in a prisoner's care.
   - Ensuring that healthcare staff attend the first case review and inviting contributions from healthcare staff if they cannot attend subsequent reviews.
   - Setting ACCT caremap actions that are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them.
   - Ensuring that all caremap actions have been completed before the ACCT is closed.

5. The Governor and Head of Healthcare should ensure that prisoners charged with homicide against a family member are referred for a mental health assessment.

6. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and ensures the control room calls an ambulance immediately an emergency code is used.

7. The Governor should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night

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 foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.	Accepted	A Notice to Prisoners will be published outlining the availability of the translation service. This notice will be published in all residential living areas, reception and prison library. A Notice to Visitors will be published outlining the availability of the translation service to provide assurance to prisoners' families. These notices will be translated in multiple languages. This information will also be reinforced via the Safer Prisons Meeting and use of the interpreting account will be monitored via the monthly finance	August 31st Res and Safety	

			meeting. A notice to staff was published on 2 February 2015 to remind staff of the importance of using the Telephone Translation Service (NTS 17/2015) In August 2015, stickers containing the translation line details were placed on telephones throughout the prison, to act as an additional reminder to staff. Since May 2015, 10 dual handset telephones (which enable both the prisoner and staff member to talk to the interpretation service) have been located in key areas across the prison. • Reception • Reception Nurses Station • G Wing 1st Night Centre x 2 • Clinic Healthcare • Resettlement Unit Minos • Well Being Unit	Complete	

			• It is the intention that one will be installed in the Separation and Care Unit. However an additional telephone line needs to be installed first. • One set is held by the Equalities Officer so that it can be moved around the establishment when required. One spare set is retained in case of faulty telephones in a key area.		
2	The Governor should ensure that foreign national prisoners who do not speak or understand English well are referred promptly for English classes.	Accepted	All prisoners identified as not being able to speak or understand English during the first night procedures will have an immediate referral to labour allocation to attend English classes.	August 31st Res and Safety Reducing Reoffending	
3	The Governor should ensure that reception staff consider and record all the known risk factors of a newly-arrived prisoner when determining risk of suicide or self-harm including information from prisoner escort records and previous prison records	Accepted	All reception staff are aware of risk factors regarding risk of suicide or self-harm. This includes partner agencies (healthcare). All staff are required to undertake ACCT training in line with the establishment training plan.	August 31st Res and Safety	

			Guidelines will be published in reception regarding consideration and recording of all known risk factors.		
4	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: ▪ Considering all known risk factors when determining the level of risk of suicide and self-harm. ▪ Holding multidisciplinary case reviews chaired by trained staff, which include all relevant people involved in a prisoner's care. ▪ Ensuring that healthcare staff attend the first case review and inviting contributions from healthcare staff if they cannot attend subsequent reviews. ▪ Setting ACCT caremap actions that are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them. ▪ Ensuring that all caremap actions have been completed before the ACCT is closed.	Accepted	All staff undertake introduction to Safer Custody training as part of the establishment training plan. This outlines the requirements of adherence to the requirements of PSI 64/2011. Emphasis is placed on the management of those prisoners at risk of suicide or self-harm. All Custodial managers have been provided with guidance notes in regards to the importance of prison staff managing prisoners at risk of suicide or self-harm in line with national guidelines and the importance of carrying out regular quality assurance checks.	Ongoing – continuous monitoring. Res and Safety	

			ACCT documents are quality assured by the Safer Prisons team and findings discussed via monthly meeting. ACCT reviews are coordinated via the Safer Custody team, to ensure the Case Manager is able to invite relevant people.		
5	The Governor and Head of Healthcare should ensure that prisoners charged with homicide against a family member are referred for a mental health assessment.	Accepted	The Head of Residence and Safety will meet with the Head of Healthcare and Head of Operations to put in place a protocol to address this issue.	August 31st Res and Safety	
6	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and ensures the control room calls an ambulance immediately an emergency code is used.	Accepted	The Head of Residence and Safety has agreed a protocol with the local healthcare provider and ambulance service. This has been published: HMP Hull Medical Emergency Response Protocol Governors Order 09/2015.	Completed Res and Safety	
7	The Governor should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night	Accepted	In the event of an emergency at night the Night Orderly Officer will ensure Healthcare staff reach the scene as	August 31st	

			quickly as possible in line with laid down guidelines contained within the Local Security Strategy (e-mail to be sent to all Custodial Managers).	Head of Security and Intelligence	

8.