



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at HMP Manchester in June 2013**

Our Vision

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

This is the investigation report into the death of a man who was found hanging in his cell at HMP Manchester just before midnight in June 2013. He was 37 years old. I offer my condolences to his family and friends.

One of my investigators had conducted this case. A clinical reviewer, a doctor, reviewed the clinical care that the man received in prison. The prison cooperated fully with the investigation.

The man was homeless, had a history of misusing drugs and alcohol and had served several previous short sentences at Manchester. He had been released from Manchester just a week before but was sentenced to prison again for repeatedly breaching an anti-social behaviour order. On his return, he was treated for alcohol and drug withdrawal symptoms but would not engage with the mental health team. He was assessed and monitored as a risk of suicide and self-harm, although many staff at the prison said that his mood was largely the same as during his previous admissions. He gave no indication of having any serious suicidal thoughts, so staff maintained a relatively low frequency of checks. When he arrived at the prison, he said that he did not want to move to a particular wing as a prisoner there had threatened to kill him. There was a miscommunication about the name of the prisoner, which meant he was not identified, and the man's fears were not discussed with him further.

The clinical review concludes that the man received appropriate treatment for his drug and alcohol problems and the investigation makes it clear that it would have been difficult for prison staff to have anticipated his actions. However, some concerns remain about the suicide and self-harm monitoring process. The day he died, he was charged with a disciplinary offence, yet there was no mention of this on his suicide and self-harm monitoring document, nor any consideration of the effect it might have on his risk. Monitoring checks were carried out at the same times every night, rather than at random intervals to ensure that prisoners cannot easily predict when the officer will visit. I am also concerned that he expressed concerns about his safety in relation to another prisoner, but this was not explored with him further as part of the suicide and self-harm prevention procedures.

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

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SUMMARY

1. The man was homeless, misused drugs and alcohol and had served numerous short prison sentences. He had been released from HMP Manchester on 28 May 2013. During the next week, he breached an anti-social behaviour order (ASBO) three times and was taken to hospital by the police after being found wandering on some waste ground near a viaduct. On 5 June, he received a six week prison sentence for breach of the ASBO and returned to prison.
2. During the reception process, the man saw a healthcare assistant, an officer, a substance misuse nurse and a doctor. He was prescribed alcohol withdrawal medication and staff began suicide and self-harm monitoring (known as ACCT) because of his low mood, withdrawal symptoms and because he indicated that he had been threatening to kill himself when the police found him near the viaduct. He said that he did not want to go to D wing as a prisoner there had threatened to kill him. There was a misunderstanding about the name of the prisoner and these alleged threats were not explored with the man further. He was allocated a cell in the prison's detoxification unit.
3. The next day, 6 June, the man saw a chaplain, a substance misuse nurse and a substance misuse doctor. The doctor prescribed methadone for opiate withdrawal. A mental health nurse saw him but he declined to engage with mental health services. He saw a member of the substance misuse team to discuss a treatment plan, but felt unwell, so this assessment was postponed for a few days until he had completed his withdrawal.
4. Because of his withdrawal symptoms, the man's ACCT assessment interview took place later in the afternoon. After this, a case review agreed that staff should check him three times during the day and four times at night. He began sharing a cell with another newly arrived prisoner. All of the staff the investigator interviewed said that the man seemed much the same in mood as during his previous times at the prison. He never voiced any active suicidal thoughts.
5. The next day, 7 June, nurses checked the man in the morning and in the afternoon and assessed that his alcohol withdrawal symptoms had lessened. During the afternoon, officers searched the man's cell and he and his cellmate were each charged with a disciplinary offence for possession of cannabis. A hearing was scheduled for the next morning. The senior officer who was in charge of the wing that day led the search but did not know the man was subject to suicide and self-harm monitoring and made no entry about this incident in his ACCT monitoring document.
6. That evening, the night patrol officer checked the man at 8.00pm. The officer planned another check at about midnight but, at 11.48pm, the man's cellmate woke up and found him hanging by a torn bed sheet from the end of the bunk bed frame. He alerted staff, who tried to resuscitate him. Paramedics arrived, but the man was pronounced dead a short time later.

7. We consider it would have been difficult to predict the man's actions that night. However, the investigation has identified some concerns about the self-harm monitoring process. No record of the disciplinary charge was made in the man's ACCT document for other staff to be aware of. He was not regarded as a high risk of suicide and self-harm and it was therefore reasonable for staff to set a low frequency of observations during the night. However, the night patrol officer conducted these checks at almost exactly the same times every night which meant he would have been easily able to predict the most opportune moment to take his own life. The man's concerns about threats from another prisoner were insufficiently investigated. The emergency response was generally swift. We make three recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners at HMP Manchester about the investigation, but no one contacted the investigator as a result. The investigator visited HMP Manchester on 12 June and met the deputy governor, investigation liaison officer, safer custody manager, duty governor at the time of the emergency and one of the prison's family liaison officers. He visited the cell where the man died, interviewed his cellmate and collected relevant records.
9. NHS England commissioned a clinical reviewer to undertake a review of the clinical care the man received in custody.
10. The investigator interviewed 16 members of staff at Manchester on 15, 16 and 24 July. He gave verbal feedback to the safer custody staff. Another investigator interviewed a prisoner who was now at HMP Garth. The investigator gave written feedback to the Governor about the initial findings of the investigation. He liaised with the coroner and the investigating police officer during his investigation.
11. A copy of our report has been sent to the local Coroner.
12. One of our family liaison officers contacted the man's brother to explain the investigation process and to ask if there were any issues he wanted the investigation to consider. His brother wanted to know the following:
 - How long had his brother been back in the community before he was rearrested?
 - What had happened to his brother before he returned to prison?
 - What was the self-harm monitoring process at the prison?
 - Where was his brother located?
 - Was there any evidence that his brother had been bullied?
13. The man's brother received a copy of the draft report. He did not identify any factual inaccuracies and we have acknowledged his comments through separate correspondence. We have provided him with a copy of the final report.

HMP MANCHESTER

14. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 male remanded and sentenced prisoners. There is 24 hour nursing care and the healthcare centre includes an inpatient unit.

Her Majesty's Inspectorate of Prisons

15. HM Inspectorate of Prisons (HMIP) last carried out an inspection of Manchester in September 2011. Their most serious concern was the number of self-inflicted deaths at the prison, which had been too high for too long. They concluded that while arrangements for caring for prisoners were not poor, there was room for improvement. The Inspectorate recommended that the prison focus on learning lessons from previous deaths.
16. HMIP were also concerned about how incidents of violence and anti-social behaviour were dealt with. They recommended better liaison between wing staff, the safer custody department and the security department to ensure that violent incidents were properly managed. However, prisoners felt safer than they had during the previous inspection. HMIP commented that Manchester had introduced a fully integrated drug treatment system service and that prisoners were able to access a full range of opiate substitution treatments.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest annual report, for the year to February 2013, the IMB commented that the prison was totally committed to safer custody and that prison staff were hard working and conscientious in ensuring the safest environment possible for prisoners.

Previous deaths at Manchester

18. We investigated five deaths at Manchester in 2012, three of which were self-inflicted. At the time of his death, the man was the only prisoner to have died at Manchester in 2013. Our recommendations in 2012 focussed on the ACCT suicide and self-harm monitoring process.
19. When we investigated the death of a prisoner in January 2012, we recommended that ACCT observations should be at unpredictable intervals with regular quality checks to see that this was happening. The recommendation was accepted and the prison said they had introduced a new robust quality assurance process. We have repeated our recommendation in this report because the night patrol officer did not check the man at random intervals during the three nights he was in custody.

Assessment, Care in Custody and Teamwork (ACCT)

20. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed.

KEY EVENTS

21. The man was homeless and well known in Manchester city centre, which he was no longer supposed to enter after the imposition of an Anti-Social Behaviour Order (ASBO). He was reported to be 80 percent deaf (although no one we interviewed said that they had any difficulties communicating with him). He misused drugs and alcohol and had numerous previous convictions. He had served a number of short sentences at HMP Manchester and had been there most recently between 20 March and 28 May 2013. There is no record that he had been assessed as a risk of suicide during previous periods at the prison.
22. After his release on 28 May, the man returned to live on the streets. On 2 June, a police officer was called to some waste ground near a viaduct in Manchester after someone reported a man sleeping rough. The officer found the man walking round in circles under the influence of drugs and alcohol. He was in breach of the ASBO but no action was taken at the time. He told the police officer that he was fed up with being homeless for so long and wanted help. He did not mention any thoughts of suicide or self-harm. The officer took the man to a hospital at his request and left him there. He was low and depressed but there were no physical symptoms which warranted admission so he was discharged. (He later said that he had wanted to kill himself by jumping off a multi-storey car park at the time, but there is no evidence of this.) He went on to breach the ASBO twice more, on 3 and 4 June, by entering the city centre area. He was arrested and taken into police custody after the third breach on 4 June.

Wednesday 5 June 2013

23. On 5 June, the man received a six week prison sentence at a magistrates' court for breaching the ASBO three times. He was taken to HMP Manchester where he arrived at 2.48pm. He was searched and placed in a holding cell before seeing a reception officer and a member of healthcare staff.
24. The man had no medication or a current methadone prescription when he arrived at the prison. A healthcare assistant saw him first and asked him about what had happened when he had been picked up by the police near the viaduct, but he was reluctant to provide details. He told the healthcare assistant that he misused heroin, crack cocaine and alcohol and was having withdrawal symptoms. The healthcare assistant told the investigator that the man had appeared distracted and laughed at some of her questions. She had got the impression that he was bored because he had been through the reception process many times before and seemed eager to leave the assessment.
25. The healthcare assistant knew the man from his previous times at the prison. She said he had appeared to be in a low mood but was not tearful or distressed. He told her that he was fed up coming in and out of prison. He said he had had enough, but was not going to do anything to hurt himself and had never previously tried to take his own life.

26. The healthcare assistant opened an Assessment, Care in Custody and Teamwork (ACCT) self-harm monitoring document because she felt that the man was vulnerable, in a low mood and withdrawing from drugs and alcohol. She was also concerned about what he said had happened when the police were called out to the viaduct. (The man's accounts to prison staff indicated that there had been an actual suicide attempt but there is no indication from the police that this was the case.) She completed the ACCT 'Concern and keep safe form' and referred him to the mental health in-reach team, although he was adamant that he did not want to be monitored under the ACCT process.
27. An officer then interviewed the man in the reception area. He told the investigator that he did not seem intoxicated, sleepy or hyperactive and interacted normally during the interview. The man told him that he did not want to move to D wing because another prisoner, who he named, had threatened to kill him. The officer telephoned a colleague on D wing, who said that there was nobody of that name living there. The officer searched the Prison Service database, which also produced no results for that name, and told the man this. Intelligence received after his death indicated that the man was referring to a prisoner with a similar sounding name, who was a prisoner on D wing at the time. No further action was taken with regard to identifying this prisoner before the man died. However, the man did not live on D wing between 5 and 8 June and never encountered that prisoner during this period.
28. The man refused a move to the vulnerable prisoner wing. An officer completed the man's cell sharing risk assessment (CSRA) and assessed him as a standard risk, meaning that he could share with another prisoner. During this assessment, he mentioned that he had tried to jump off a ten storey car park on Sunday 2 June but had been stopped by the fire brigade. This appears to have been an exaggeration of what happened on waste ground near a viaduct, when the police picked up the man and took him to hospital. The fire service has no record of any such incident on this date. The man told the officer that he had no intention of killing himself.
29. The man declined the offer of a telephone call. He told the officer that he would not be contacting anybody and refused to sign the communications compact. He did not make any telephone calls while he was at Manchester. The officer did not ask him about his next of kin because escort staff had written 'No fixed abode' on the relevant section of the form. He assumed that the escort staff had already discussed this with him and no family details had been given.
30. An officer, healthcare assistant and a supervising officer (SO) completed an ACCT 'Immediate Action Plan' in the reception area at 5.55pm. The man was to see the doctor and move to the detoxification unit. He was also referred to the mental health team. Staff were required to make frequent and irregular observations until a fuller version of the immediate action plan could be completed. It is standard practice for staff to complete two immediate action plans at Manchester if an ACCT document is opened for a prisoner in the

reception area. One is completed in the reception area and the second later in the evening once the prisoner has moved to his residential wing.

31. A Substance Treatment and Recovery (STAR) team nurse reviewed the man in the reception area. She had met him many times before during his previous admissions. He told her that he was fed up with living on the streets and was frustrated with himself for being arrested again. He was eager to move straight to his cell. The nurse told the investigator that the man's mood and behaviour seemed much the same as always. He was quiet because he was withdrawing. He was irritable, sweaty and his eyes were dilated, but he was not having any tremors. She asked about suicidal thoughts and he told her that he was not thinking of harming himself and did not want to be subject to ACCT monitoring. She did not record any mental health concerns.
32. When he was released from prison on 28 May, the man had been prescribed methadone (a heroin substitute) but he had not collected his prescription. Instead, he told the STAR team nurse that he had been misusing illicitly obtained methadone and diazepam (a benzodiazepine also known as Valium), drinking alcohol and smoking heroin and crack cocaine every day for the last week. His urine tested positive for opiates, methadone, benzodiazepines and cocaine.
33. The STAR team nurse arranged for the man to be reviewed by the reception GP, transferred to the detoxification unit and seen by the STAR team doctor the next day. She scored him 9 on the Clinical Opiate Withdrawal Scale (COWS). A score of 12 or more would indicate a need for immediate treatment with methadone. She scored him 13 on the Clinical Institute Withdrawal Assessment for Alcohol. The threshold is 10, so he required immediate medication for alcohol withdrawal symptoms. She scored him 22 for benzodiazepine withdrawal, the threshold for treatment being 30. She based her scores on her observations and questions, a urine test and the blood pressure reading taken by the healthcare assistant.
34. At about 6.00pm, the reception GP saw the man. The doctor read the healthcare assistant's entry in the clinical record referring to what the man had described as a suicide attempt near a viaduct and raised this issue with him. He said that he did not have any suicidal thoughts and was unhappy about ACCT monitoring. He said he was frustrated about going in and out of prison. The reception GP thought that the man was subdued but not psychotic or suicidal. He arranged an alcohol detoxification plan and prescribed chlordiazepoxide, thiamine (vitamin B1) and vitamin B to treat alcohol withdrawal and ibuprofen, metoclopramide and paracetamol to relieve any withdrawal symptoms. His medication was to be administered under supervision.
35. The man moved into a cell on the fourth landing of I wing, the detoxification wing. An officer (who normally works at HMP Woodhill) completed the man's induction interview on I wing. He said he was of no fixed abode and did not wish to provide next of kin details. A supervising officer (SO) and a principal officer (PO) then completed a second ACCT 'Immediate Action Plan'. The

man told the SO that he was not thinking about harming himself. Until his first proper ACCT case review the next day, staff were required to have three conversations with him during the day and check him four times at night at irregular intervals.

Thursday 6 June

36. The next morning, the STAR team nurse wrote a 28 day substance misuse care plan in the man's clinical record. At 8.20am, the Anglican chaplain spent about five minutes with the man. (A member of the chaplaincy team is expected to see every new prisoner within 24 hours.) He cooperated but did not seem particularly interested and spoke monosyllabically. The chaplain recognised that the man knew the reception procedures very well and was probably bored with a familiar routine. He said that he had felt low and frustrated the night he returned to prison but he was not having any suicidal thoughts. The chaplain recalled in interview that he was quite dismissive and she felt that he was fed up being asked about what had happened when the police had been called out to the viaduct.
37. A member of the primary care mental health team then began a mental health triage assessment with the man. The mental health team had no record of treating him before, but he had been referred on this occasion because he was subject to ACCT monitoring. He seemed relaxed and initially engaged, but he then refused to speak to the nurse and said he had no intention of cooperating with the mental health team. He laughed at her during the assessment and told her she was funny. She got the impression that he was humouring her, was not taking the assessment seriously and just wanted it over with. She advised him that he could contact the mental health team if he needed support.
38. The nurse from the primary care mental health team told the STAR team nurse that the man had refused to engage with the mental health team. The STAR team nurse then reassessed the man's withdrawal scales and found that it was now appropriate to prescribe methadone for opiate withdrawal.
39. The STAR team doctor who had known the man for six years, saw him shortly after 9.00am. He told the investigator that the man seemed to be suffering quite badly from withdrawal symptoms but otherwise his mood was no different from their previous encounters. He had not slept well and was subdued. He wanted the interview to be over as quickly as possible so that he could go back to bed. The doctor found it difficult to keep him engaged. He knew the standard procedure and just wanted to get on with it. He said that he was unhappy about not having anywhere to live and frustrated about serving another short prison sentence, but did not have any suicidal thoughts.
40. The STAR team doctor began a new methadone prescription, gradually increasing the dose over a five day period from 10ml to 40ml per day, with a review by a nurse on the fifth day. He also prescribed a reducing dose of diazepam over several days instead of the previously prescribed chlordiazepoxide (they are both benzodiazepines). The diazepam

prescription was to help withdrawal from alcohol and illicit benzodiazepines and would end once the man was on a stable dose of methadone. The STAR team doctor continued the alcohol detoxification plan begun by the GP on reception.

41. After he had been seen by the STAR team doctor, his allocated support worker from the STAR team saw him for an initial assessment. She told the investigator that he looked fed up, tired and unkempt but did not have any shakes or tremors. However, he said that he was not feeling well enough to complete a full assessment interview because he was suffering from withdrawal symptoms. The support worker spent only about ten minutes with the man and agreed to come back on Monday 10 June to complete a full assessment. This would still have allowed her to complete a care plan within the five day target. She believed that he would be willing to engage once he had stabilised. In the meantime, she completed an alert form for the local drug team in anticipation of his release back into the community three weeks later, as he would need a continuation of his methadone prescription.
42. The man was due to be interviewed for an ACCT assessment at 10.50am but declined, saying that he felt too ill to participate. The STAR team nurse checked him again in the early afternoon. He was still experiencing withdrawal symptoms but his mood was the same.
43. During the afternoon, the man was discussed at the weekly multidisciplinary team allocations meeting. The nurse from the primary care mental health team informed the meeting that the man had declined a mental health assessment but remained under the care of the STAR team for detoxification, remained on an ACCT and knew how to access the mental health team if he wanted to re-engage.
44. A principal officer (PO) was in charge of H and I wings and spoke to the man, who said that he was now willing to attend his ACCT assessment interview. At 3.30pm, an officer completed the man's ACCT assessment interview, which took just under half an hour. He seemed uncomfortable and looked really unwell but, although he was initially reluctant, he was willing to chat. His mood was low and he told the officer that he was sick of coming in and out of prison and taking drugs. He said that he was tired and wanted to sleep. He said that he had jumped off a roof on Sunday because of the thought of returning to prison but the fire brigade had broken his fall. (Again, he appears to have been exaggerating what had happened when the police found him at the viaduct).
45. The officer asked the man if he wanted to be dead and he told her that he had never tried to hurt himself before. He said that he did not want to die in prison and had no current suicidal thoughts. However, he also said that he had no reason for living, no family and was adamant that he did not expect any visits. He was still low in mood and withdrawing from alcohol and drugs. They agreed that he should complete his detoxification plan and access help with housing. He talked about release and future plans. The officer did not think that he was at imminent risk of harming himself.

46. Immediately afterwards, the principal officer (PO) chaired the first ACCT case review, which the chaplain and an officer attended. The man was polite and cooperative although he still felt low. He spoke openly about his frustration and said that he wanted to break the cycle of drug and alcohol abuse and leave Manchester. He wanted a normal life, a family and a job. He said that he had found his experience near the viaduct a few days earlier frightening and that he would not do anything similar again. He seemed quite motivated to change and appeared to be thinking positively. He said that he had never harmed himself in custody.
47. Although the man's mood seemed much the same as when they had previously met, the principal officer (PO) decided to keep the ACCT document open because he was withdrawing from drugs and alcohol and seemed vulnerable. He assessed the risk of self-harm as low. He took into account the man's mood during the review, that he did not have any suicidal thoughts and his plans for future change. However, he also acknowledged that the man was withdrawing and had apparently recently considered jumping from a height. The ACCT review panel agreed that the same frequency of observations should be maintained, with staff required to have three conversations with him each day and conduct four random checks during the night between 9.00pm and 6.30am. The principal officer and the officer told the investigator that, on the basis of the evidence that was available at the time, they were fully satisfied that the risk assessment and frequency of observations were appropriate.
48. The principal officer (PO) wrote two actions on the ACCT care map: re-engagement with the STAR team and referral to the housing officer. The man said he was now keen to work with the STAR team. The principal officer emailed the support worker's manager to let him know of the man's renewed willingness to engage. The principal officer also contacted the housing officer who agreed to explore the man's housing options with him. Later in the afternoon, the principal officer spoke to the man and told him that the housing officer would be looking at his case. The next ACCT review was due to be held seven days later.
49. That evening, the man and another newly arrived prisoner moved into cell 10 together on the first landing of I wing. The man had asked staff to move him from the fourth to the first landing as he was feeling too weak to walk up the stairs. The newly arrived prisoner told the investigator that he did not know the man well but had sometimes seen him in the city centre over the years. He thought that he seemed 'off his head', dopey, depressed and sleepy. They did not talk much that night.

Friday 7 June

50. The next morning, a nurse reviewed the man and recorded no particular concerns. She rescored his Clinical Institute Withdrawal Assessment of Alcohol and scored him as 4. (The threshold for treatment is 10.) His treatment continued for the time being. Later that morning, a member of the

Manchester Drugs Team from the community contacted the healthcare team to check the man's progress in custody.

51. At about 2.40pm, a nurse reviewed the man and also scored his Clinical Institute Withdrawal Assessment of Alcohol as 4. The nurse told the investigator that this was a typical score for a third day in custody when a prisoner tends to be past the acute phase of withdrawal. His blood pressure was normal but his pulse was a little fast.
52. At 3.00pm, a senior officer (SO) received information from a prisoner which prompted him to search the man and his cellmate's cell with two officers. They found that both men had packages of cannabis resin in cling film which they had tried to conceal in their socks. However, they did not resist when these packages were found. The man complained that somebody had 'stitched him up', but did not appear too upset about it. Both men were charged with an offence under Prison Rules. At 6.00pm, an officer issued the man with his notice of report, which indicated that his disciplinary hearing was scheduled for 10.10am the next morning. The man and his cellmate remained in the same cell.
53. The senior officer (SO) usually managed K wing and did not check the ACCT documents on I wing (as he would normally be expected to do as the wing manager). He did not know that the man was subject to self-harm monitoring and therefore did not make an entry in the ACCT document about the incident.
54. At about 5.00pm, the man collected his evening meal and medication. An officer completed an ACCT check on him at 7.10pm when he was locked in his cell. He was asleep and very still so the officer asked the man's cellmate to rouse him. The man was reluctant to engage but spoke briefly.
55. The night shift staff arrived at about 8.00pm. One officer worked on each of the four wings which form the top part of the prison. Officers and nurses at Manchester carry keys at night so they can move between the wings. Officers also carry a cell key in a sealed pouch to be opened in an emergency.
56. An officer completed an ACCT check on the man at 8.00pm when he noted that he was asleep on his back on the bottom bunk on top of his covers. His cellmate told the officer that the man was fine. The officer saw the man breathing and then turn over.
57. There were five prisoners on ACCT documents on I wing that night, who were supposed to be checked four times during the night. An officer checked all five prisoners at about 8.00pm. He planned to check the five prisoners for a second time shortly before midnight, but was delayed by having to collect and return a Samaritans telephone from H wing for a different prisoner because the I wing telephone was not working. (Prisoners can be given a dedicated cordless telephone to call the Samaritans at any time of night.)

58. The investigator asked his cellmate if the man had spoken to him about taking his own life. He said that the man had not voiced any specific suicidal thoughts, but had remarked, "I am going in my time, not their time." This remark had not seemed significant to his cellmate at the time. He told the investigator that, if he had had any suspicion that the man planned to take his own life, he would have told the staff. He did not see him take any drugs or illicit medication before his death. He said that he fell asleep at about 8.30pm with the television on.
59. The man's cellmate later woke up in the dark. The television was on with the volume turned up. He got up to use the toilet and bumped into the man. He turned the light on and saw that he had tied a piece of torn bed sheet around his neck and had hanged himself by attaching the other end to the top of the bed frame. He was kneeling at the end of the bed next to the toilet facing the corner of the cell. CCTV footage shows that his cellmate pressed the cell bell at 11.48pm and 50 seconds because a light appeared outside the cell at that time.
60. The officer had just returned to I wing after putting the Samaritans telephone back on H wing when he heard the cell bell and saw a flashing light on the indicator panel showing it came from a cell on the first landing. He walked downstairs from the fourth landing, saw the cell bell indicator lit up outside cell 10 and reached the cell door at exactly 11.51pm according to the CCTV footage. He did not run as there was nothing to indicate that there was an emergency.
61. The officer looked through the observation panel and saw the cellmate, who pointed to the man at the back of the cell and said that he was hanging. The officer asked the cellmate to support the man's weight and radioed a priority 1 call (the current emergency code at Manchester indicating a life-threatening situation) to the control room stating, 'All staff to attend cell I-10'. The officer then broke the seal on his emergency key pouch and unlocked the cell door. He entered the cell at 11.51pm and 50 seconds and crouched down to help the cellmate support the man's weight.
62. Two officers reached the cell at exactly 11.52pm and a further officer arrived five seconds behind. Two of the officers supported the man's weight while the third removed the bed sheet from his neck. The knot came loose within a couple of seconds so the officer lifted it over the man's head because this was easier and quicker than using his anti-ligature knife.
63. The officers laid the man on his back on the floor by the side of the bed with his head nearest the door. They removed his cellmate, who was very shocked, and then put him in a crisis suite on G wing with a Listener. (Listeners are prisoners specially trained by the Samaritans to support other prisoners in distress.) An officer checked the man for a pulse, could not find one and began performing chest compressions. (He had previously received cardiopulmonary resuscitation training, although this was out of date.)

64. Two nurses were on duty that night and both were in the healthcare centre between the two different parts of the prison when they heard the emergency message. The night orderly officer in charge of the prison and the assistant night orderly officer were with them at the time, so all four of them went directly to I wing.
65. A further nurse reached the cell with the two orderly officers at 11.52pm and 45 seconds. The night orderly officer then asked for an ambulance to be called. The control room staff telephoned the ambulance service at about 11.53pm. A nurse arrived at exactly 11.53pm after collecting two emergency medical bags from the centre area containing a defibrillator, airways, an ambu-bag and oxygen. The officer continued performing CPR while the two nurses prepared their equipment. They then took over the resuscitation effort. The nurses attached the defibrillator to the man but the machine could not find a shockable heart rhythm and advised them not to shock him. (An automated external defibrillator analyses heart rhythm and delivers electric shocks to victims of cardiac arrest when it determines there is a rhythm that is likely to respond.) The nurses inserted a plastic airway and used an ambu-bag to circulate oxygen to try to help him breathe.

Saturday 8 June

66. Two paramedics arrived in an ambulance at the prison gate at about 12.06am and reached the wing at 12.10am and 30 seconds. They continued the resuscitation effort but then identified that pooling of blood in both the man's legs and his back was a clear indication that he had died. The two nurses agreed and they pronounced him dead at about 12.14am.
67. Police found a piece of card with handwriting on it in the man's cell. Because he was dyslexic, he had asked his cellmate to help him. His cellmate had written out this sentence: 'I'm being encouraged to do things I don't want to do for my family's safety and wellbeing.' He had then tried to copy out this sentence underneath.
68. Staff reviewed all prisoners subject to ACCT monitoring in the prison after the man's death. A debrief meeting for staff involved in the emergency incident was held after he died, to ensure they had appropriate support.
69. One of the man's brothers was a prisoner at HMP Kirkham, so prison staff there broke the news to him. The family liaison team contacted another of the man's brothers, who acted as his next of kin and arranged his funeral. His funeral was held on Wednesday 26 June. The prison contributed towards its cost in line with national guidance.
70. A toxicologist identified therapeutic levels of diazepam and ibuprofen and traces of cannabis in tests conducted after the post-mortem examination. The toxicologist found no trace of alcohol or any other illicit drugs. The report identified a concentration of methadone in the man's system which would be normally be considered a high level but would be regarded as a therapeutic level for habitual users who had developed a tolerance.

ISSUES

Drug and alcohol treatment

71. A clinical reviewer completed a review of the man's clinical care. He found that the man received appropriate treatment for his drug and alcohol withdrawal symptoms and that there were regular follow-up assessments. He thought that the man received care equivalent to that he could have expected to receive in the community. He noted that the mental health team spoke to him but that he had declined to engage with them.

Assessment, Care in Custody and Teamwork (ACCT) monitoring

72. Staff opened an ACCT document for the man on 5 June. He was then charged with a disciplinary offence on 7 June after the senior officer received intelligence, ordered a search and found cannabis on the persons of both the man and his cellmate. Both men were charged and were due to attend a disciplinary hearing the next morning. We do not wish to overstate the significance of the cannabis find and the pending disciplinary hearing, however, nobody made an entry in the ACCT ongoing record about him being found with drugs and the subsequent disciplinary charge. Prison Service Instruction (PSI) 64/2011 about the management of prisoners at risk of self-harm states:

'It is vital that the on-going record contains sufficient information about the progress and well-being of the prisoner. This information is critical to ensure that the risk is being managed appropriately...'

73. Wing managers are supposed to know which prisoners have open ACCT documents so they can make informed judgments. The senior officer usually managed a different wing and did not check whether the man was subject to ACCT monitoring. Consequently, he did not make an entry in the ACCT document after the cell search.
74. The senior officer told the investigator that, had he realised that the man was subject to ACCT monitoring, he would still not have scheduled an immediate ACCT review after the cell search. We agree that the evidence available at the time did not suggest that a formal ACCT case review would have been necessary. He was an experienced prisoner and did not become distressed after the cell search. When the police later interviewed his cellmate, he said that the man had not been bothered by the prospect of a disciplinary hearing and expected to have only a few days added to his sentence. However, the senior officer should have at least been aware that he was being monitored, checked his welfare and made an entry in the ACCT document about the cell search. We make the following recommendation:

The Governor should ensure that wing managers familiarise themselves with all open ACCT documents on their wing at the start of each shift and that any significant event is recorded in the ongoing record.

75. Apart from this man, four other men were subject to ACCT monitoring on I wing on 7 June. All five men were supposed to be checked four times overnight. An officer told the investigator that four checks during the night is the usual number for prisoners subject to ACCT monitoring at Manchester. He told the investigator that he had got into the habit of checking prisoners at the same times every night. His regular routine is to check the prisoners at 8.00pm when he arrives, then again at about midnight, again between 2.30am and 3.00am and then finally between 5.30am and 5.45am during the roll check. He told the investigator at interview that, on 7 June, he did not check any of the five prisoners between 8.00pm and the time the man's cellmate discovered him and pressed the cell bell.
76. The officer had checked the man during his first two nights at the prison, and the ACCT document confirms that his checks were at very similar times. Four checks during the night was a reasonable frequency of observations, commensurate with the man's level of risk at his first ACCT case review. This frequency results in intervals of two to three hours between checks. If a prisoner decides to take his own life, these intervals present a clear opportunity to do so, but carrying out the checks at almost exactly the same time every night reduces their effectiveness. We repeat a recommendation which we made after an investigation into the death of a prisoner at Manchester in January 2012:

The Governor should ensure that staff conduct ACCT observations at unpredictable intervals and that this practice is enforced by regular quality checks.

Bullying

77. When the man arrived in prison, he asked to be kept separate from a prisoner on D wing who he said had threatened to kill him. He appears to have given his surname incorrectly, or it is possible this was misunderstood by the reception officer. The officer checked computer records and spoke to an officer on D wing, but was unable to find that name. After the man died, and more security information was obtained, this prisoner was identified. We are surprised that this link was not established beforehand, or that he was not asked for further information about this. It is possible the miscommunication was a result of his deafness.
78. After the man died, the same prisoner informed prison staff that he had a bag of the man's property, including a CD player and clothing, which he said the man had given him to keep safe at the end of his last sentence. He said that he had been worried about the man being bullied by others and had wanted him to be brought to live on D wing, where he could look after him. He volunteered to speak to our investigator to offer any help he could. Prison staff suspected that he was trying to appear helpful in order to deflect attention away from himself.
79. On 11 June, staff received security information which indicated that this prisoner had been bullying and threatening the man. This intelligence

suggested that the man had been bringing drug parcels into prison for this prisoner, but had refused to bring in any more. This prisoner had then allegedly made it clear to the man that he would be picked up at the gate and shot when he was released from prison towards the end of June.

80. At the end of June, the same prisoner asked for another prisoner to be brought to live near him on D wing. Prison staff suspected that, because he was serving a long sentence for conspiring to supply and import class A drugs, and the other prisoner was due to be released a week later, he might be planning to ask this prisoner to bring contraband into prison either on visits or by getting rearrested. Staff's suspicions were raised after the man's death by intelligence they had received about this prisoner bullying the man.
81. When one of our investigators interviewed that prisoner, he insisted that he and the man had been friends and that he had agreed to look after his property because he was returning to live on the streets when he was released on 28 May. He denied bullying the man during a previous sentence or asking him to bring drugs into prison.
82. When the man was found in possession of cannabis on 7 June, there was no evidence either to confirm that he had brought these drugs into prison on 5 June or that another prisoner had coerced him. This prisoner and the man could not have met between 5 and 8 June because D wing and I wing are in separate parts of the prison. While the man might have been anxious about meeting him later during his stay at Manchester, there was no possibility of direct intimidation before his death.
83. It is not possible to know whether previous encounters with this prisoner or other prisoners had any bearing on the man's decision to take his own life. He left no clear indication of his reasons. He was very deaf and small in stature, so it is possible that he might have been susceptible to victimisation. However, there is no evidence that allows us to reach any definite conclusions. Although he wrote on a piece of card in his cell, the message was not clear and did not identify any specific issues which we might have been able to investigate but there is an implication that this prisoner felt threatened or coerced. However, there is insufficient evidence to allow us to reach a definite conclusion.
84. Prison staff did not receive any direct intelligence about this prisoner allegedly bullying the man before his death. However, we are concerned that further efforts were not made to discuss with the man his concerns that another prisoner had made threats to kill him. This is particularly surprising as he had been identified as a risk of suicide of self-harm and vulnerable yet his concerns that he was being threatened do not seem to have been pursued with him as part of the ACCT or through violence reduction procedures at the prison. This office has previously identified the potential link between intimidation and suicide including in our 2011 publication, 'Learning from PPO investigations: Violence reduction, bullying and safety' and there is a need for prisons to ensure that any information about vulnerability is thoroughly investigated and acted on. We make the following recommendation:

The Governor should ensure that all information about threats and intimidation is fully investigated and discussed with prisoners who are subject to ACCT monitoring.

RECOMMENDATIONS

1. The Governor should ensure that wing managers familiarise themselves with all open ACCT documents on their wing at the start of each shift and that any significant event is recorded in the ongoing record.
2. The Governor should ensure that staff conduct ACCT observations at unpredictable intervals and that this practice is enforced by regular quality checks.
3. The Governor should ensure that all information about threats and intimidation is fully investigated and discussed with prisoners who are subject to ACCT monitoring.

ACTION PLAN: [man's name] HMP Manchester June 2013

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion | Progress (to be updated after 6 months) |
|----|--|-----------------------|---|----------------------------|---|
| 1 | The Governor should ensure that wing managers familiarise themselves with all open ACCT documents on their wing at the start of each shift and that any significant event is recorded in the ongoing record. | Accepted | This has been communicated and reinforced to all staff via a Notice to Staff. Wing managers are now routinely asked on a daily basis via a morning operational briefing to confirm their awareness of ACCT documents in their area. | In place | |
| 2 | The Governor should ensure that staff conduct ACCT observations at unpredictable intervals and that this practice is enforced by regular quality checks. | Accepted | This has been communicated to all staff via a Notice to Staff. The necessity to conduct unpredictable and irregular observations has been included in the Quality Assurance process which is monitored at senior manager level. Further quality assurance checks are also made by the Safer Custody Department. | In place | |
| 3 | The Governor should ensure that all information about threats and intimidation is fully investigated and discussed with prisoners who are subject to ACCT monitoring. | Accepted | A new system of monitoring information relating to bullying and threats has been put in place with the Violence Reduction Co-ordinator liaising directly with the safer custody co-ordinator and security. Investigation and follow up actions are tracked through the safer custody office. Where risk is identified support measures are put in place and identified perpetrators are appropriately challenged. | In place | |

