PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in March 2014 at HMP Hewell

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 hanged in his cell at HMP Hewell in March 2014. He was 39 years old. I offer my condolences to his family and friends.

A review of the clinical care and treatment the man received at Hewell was undertaken. The prison cooperated fully with the investigation.

On 17 March 2014, the man was remanded to HMP Hewell charged with attempted arson with intent to endanger life. He disclosed a recent suicide attempt but said he had no current suicidal thoughts. Despite a range of factors which increased his risk of suicide and self-harm, the reception officer and nurse did not assess him as at risk but a doctor who saw him later that evening thought otherwise and started suicide and self-harm prevention procedures. The doctor referred him for a mental health review and recorded in his clinical record that he needed a shared cell and frequent staff observations. This was not noted in his suicide and self-harm monitoring document.

The man shared a cell and appeared to settle at the prison. He continued to be monitored and managed under suicide and self-harm procedures. Despite his risk factors, all of the staff who dealt with him considered him to be at low risk as he said that he had no intention of harming himself.

One afternoon in March, staff moved the man's cellmate to another cell and told him that he would get a new cellmate that evening. Just before 8.00pm, an officer took a new prisoner from reception to the cell. When he unlocked the door, he found him hanging. Prison staff and paramedics attempted to resuscitate him, but without success.

The man's recent history included a number of events that put him at risk of suicide and self-harm and I am concerned that the reception officer and nurse who first assessed him did not identify this. However, suicide and self-harm prevention procedures began appropriately when a doctor recognised his level of risk. I recognise that he gave little indication of his intentions, and assessment of risk is a matter of individual judgement, but I consider that prison staff managing him relied too much on his protestations that he did not intend to harm himself, rather than his known risk factors. This led to them assessing his risk of suicide as low and setting infrequent observations. I am also concerned that, although a mental health nurse had identified the need for a doctor to review him for anti-depressant medication, there is no evidence this referral was ever made.

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 **December 2014**

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SUMMARY

1. The man arrived at HMP Hewell on 18 March 2014 after he had been charged with attempted arson with attempt to endanger life at his estranged wife's home. He had been in prison once before, in 1999. When he arrived at Hewell, he disclosed that he had recently tried to kill himself but said he had no current thoughts of suicide. He was an alcoholic and a doctor prescribed medication as part of an alcohol detoxification programme. The doctor began Prison Service suicide and self-harm prevention procedures (known as ACCT) as he recognised that he had a range of risk factors for suicide and self-harm, including the nature of his offence, his recent suicide attempt and his withdrawal from alcohol. The doctor noted in his medical record that he needed to share a cell and staff should observe him frequently but he did not record this in the ACCT document. He was observed once an hour, until his first ACCT review.

2. The man moved to a shared cell on Houseblock 4, which holds prisoners with drug and alcohol problems. The next morning, 18 March, an officer interviewed him for an ACCT assessment, when he reiterated that he had no current thoughts of suicide. The officer who interviewed him was satisfied with his assurances and noted that he engaged well with her. Despite his recent suicide attempt and other risk factors, a first ACCT case review assessed him as at low risk of suicide and self-harm. Levels of observations were set at four times during the day and once an hour at night.

3. At a mental health assessment after the case review, the man told a nurse that he had had no previous contact with mental health services and had no history of self-harm. However, the nurse noted that he had recently taken an overdose of 500 paracetamol tables combined with a bottle of vodka. The nurse identified that he needed to see a doctor to consider prescribing antidepressant medication but there is no evidence that she made a referral.

4. None of the prison staff who had contact with the man in the following days noted any concern that he was at imminent risk of suicide or self-harm. On 21 March a further ACCT review, held by a single member of staff, again assessed his risk as low but kept the ACCT open as the officer considered that he did not know him sufficiently well. The officer reduced his night-time observations to once every two hours and daytime observations to one each session (morning, afternoon and evening). No changes were made to the ACCT caremap. He completed his alcohol detoxification programme on 22 March. Staff did not identify any further concerns about him.

5. One afternoon towards the end of March, prison staff moved the man's cellmate to another cell. When he was locked in his cell at 6.15pm the officer told him that he would get a new cellmate later that evening.

6. At about 7.55pm, an officer brought two prisoners from reception, one to share the cell with the man. When the officer unlocked the cell, he found him hanging by a ligature made of a twisted bed sheet tied to a wall cabinet. The officer radioed an emergency code and, assisted by the two prisoners, untied the

ligature and lowered him to the floor. The officer began to give chest compressions to attempt resuscitation. Nurses arrived quickly and continued to attempt resuscitation. Paramedics arrived soon after and took over emergency treatment. At 8.36pm, the paramedics pronounced him dead.

7. We are concerned that the reception officer and nurse did not immediately identify the man's risk of suicide and self-harm when he first arrived. It is also concerning that at ACCT reviews prison staff assessed his risk as low, despite his recent serious suicide attempt and other evident risk factors. This in turn led to a very infrequent level of observations and him being left in his cell alone on the evening he hanged himself. His mental health assessment was not progressed as it should have been. We make five recommendations.

THE INVESTIGATION PROCESS

8. We issued notices to staff and prisoners at HMP Hewell, informing them of the investigation and inviting them to contact the investigator if they had relevant information. No one responded.

9. On 25 March 2014, the investigator visited Hewell and arranged to obtain copies of the man's prison and healthcare records. He later interviewed 15 members of staff and one prisoner at Hewell.

10. The investigator informed HM Coroner for Worcester of the investigation and we have sent him a copy of this report.

11. NHS England (Shropshire and Staffordshire Area) appointed a clinical reviewer to review the man's clinical care at Hewell.

12. One of the Ombudsman's family liaison officers contacted the man's mother, his nominated next-of-kin, to inform her of the investigation and to ask if she had any issues that she wanted the investigation to consider. She wanted to know:

    - Was her son being checked, as he was at risk of self-harm?
    - What time her son was found hanging?
    - How her son had been able to hang himself from a cupboard which she did not think could have taken his weight?
    - Why her son had bruising to his face?

13. The man's mother received a copy of the draft report and said she was satisfied with the findings.

HMP HEWELL

14. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. The man was at the Blakenhurst site which comprises six houseblocks, holding up to 1074 men. Health services are provided by Worcestershire Health and Care NHS Trust.

HM Inspectorate of Prisons

15. The Inspectorate of Prisons carried out an unannounced follow-up inspection of HMP Hewell in November 2012. Inspectors found that incidents of self-harm had increased since the time of the previous inspection in 2009, as had the number of ACCTs opened. The reason for this had not been established as monitoring data was not being used to inform the safer custody strategy. Inspectors found that some prisoners subject to ACCT were receiving inadequate care. They found that initial assessor reports were generally good, but that there was little evidence of multidisciplinary attendance at case reviews. The standard of ACCT entries was mixed and many were simply observational.

16. The report of a more recent inspection in July 2014 has not yet been published but in their interim feedback inspectors reported that ACCT procedures required improvement in several areas: they found that the underlying causes of prisoners' crises were not always addressed; case reviews were often insufficiently multi-disciplinary; and many identified triggers for self-harm focussed on past rather than future events.

17. Since the last inspection there had been seven deaths in custody, three of which were self-inflicted. Inspectors found that there was limited dialogue between relevant departments to ensure recommendations from death in custody investigations were being addressed.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In their 2012/13 annual report, the Board commented on a significant increase in incidents of self-harm at Hewell in the past few years. The Board noted that while the reasons for these increases were not entirely clear, prison staff were more aware and vigilant after the introduction of a safer custody policy in 2012. The Board considered that this accounted for the significantly increased numbers of self-harm monitoring documents being opened.

Previous deaths at Hewell

19. The man's death was the sixth apparent self-inflicted death at Hewell since January 2012. In two of these other cases the prisoners died while being managed under ACCT procedures. One of these investigations found that the

prisoner's risk factors should have resulted in an ACCT being opened when he first arrived at the prison.

Assessment, care in custody and teamwork (ACCT) procedures

20. Assessment, Care in Custody and Teamwork (ACCT) is a Prison Service process for supporting and monitoring prisoners thought to be 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. 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) 64/2011.

KEY EVENTS

21. In the early hours of 15 March, the man went to his estranged wife's home and poured white spirit through the letterbox and attempted to start a fire. He then made an anonymous call to the fire service to report a fire. When the fire service went to the house they found that only the front door had been scorched. He went to Walsall police station the following morning and confessed to what he had done.

22. The man remained in police custody for the next two days. The police charged him with attempted arson with intent to endanger life and he appeared in court on 17 March. He was remanded to HMP Hewell where he arrived at 5.15pm. The Person Escort Record (PER) that accompanied him from court noted that He was an alcoholic and had taken an overdose in 2013. (The escort record gave no further details and it possible that this was a mistaken reference to a suicide attempt he had made around ten days earlier.)

23. The prison has not been able to locate the man's induction records but a Supervising Officer (SO) told the investigator that, although he could not recall him, he would have checked him into the prison that afternoon as he was the reception SO on duty that day. The SO said that he might open an ACCT if there were clear self-harm or suicide warning on the PER but would otherwise assess prisoners' risk based on their presentation.

24. A nurse saw the man in reception for a health screen. He said that he had taken a number of recent drug overdoses after his marriage had broken down, but said he did not have any current thoughts of suicide and self-harm. He said that he had not used drugs in the previous month but said that he drank heavily. The nurse referred him to the doctor to consider treatment for alcohol dependency.

25. The nurse told the investigator that he accepted that the man had a number of significant risk factors for suicide and self-harm, including the breakdown of his marriage, his alleged offence of arson and recent suicide attempts by drug overdoses. He said that he had decided not to open an ACCT because he had said several times that he was not at further risk of self-harm and because of the positive way he had presented. The nurse said that, in his experience, people can have found themselves in a chaotic situation in the community but when they come to prison say they are then trying to move forward with their lives as they have been removed from that situation.

26. The man would then have seen a reception officer who should also have assessed his risk of suicide and self-harm. We have not been able to establish who this officer was as the prison has lost the reception records.

27. A doctor saw the man later that evening. He noted his reported use of alcohol and prescribed chlordiazepoxide for alcohol detoxification. The man told him about his most recent overdose on 9 March when he said that he had taken 500 paracetamol tablets with two litres of vodka. He had then spent five days in hospital. He said this had been a genuine suicide attempt in response to the

breakdown of his marriage. He said he was depressed but did not want to kill himself. The doctor was concerned about him and opened an ACCT. He told the investigator that, in his experience, those who say they want to kill themselves do not tend to do so while those who deny such an intention, do.

28. The doctor noted in the man's clinical record that he should ideally be in a shared cell with frequent staff observations, but did not note this on the ACCT document. He told the investigator that he had been told during ACCT training that it was not a doctor's role to advise on the level of observations or whether a prisoner should share a cell. The doctor referred him for a mental health review.

29. A SO who was working in reception that evening saw the man to complete an immediate action plan as part of the ACCT process to keep him safe until his first review the next day. She noted on the ACCT document that he should be observed twice an hour until he had had his ACCT assessment. He went to a shared cell on Houseblock 4, which holds prisoners withdrawing from drugs or alcohol. She told the investigator that, had she known about the doctor's entry in his clinical record, she would still have set two observations an hour as an appropriate level of frequency. Despite the SO's instruction, he was observed only once each hour through the night.

30. The next morning, 18 March, an officer interviewed the man for an ACCT assessment to help identify his main concerns and how his risk could be reduced. He repeated what he had said before about the breakdown of his marriage and that he had taken an overdose as a result. He said that he no longer wanted to die but needed help to sort out his life. She told the investigator that he engaged well. She noted that he was low in mood but said that she had no reason to doubt it when he said he did not want to end his life.

31. A custodial manager held the man's first ACCT case review later that morning, with another custodial manager and a nurse. The officer did not attend but had briefed the manager about her assessment. The manager noted in his summary of the review that the man was very upset about his situation but said he had no current thoughts of suicide or self-harm. The review assessed him as at low risk. The manager told the investigator that, had he known him, he would have considered closing the ACCT. The review reduced the man's night-time observations to one an hour. Daytime observations were set as two in the morning and two in the afternoon. His caremap listed four issues: alcohol detoxification; mental health review; prison induction and to start education or employment. The next ACCT review was scheduled for 21 March.

32. A nurse saw the man for a mental health review soon after the ACCT review. She noted that he was clean, polite and appropriate in his manner, although a little tearful. She found no evidence of thought disorder although assessed that he was in a low mood and was a little tearful. She recorded that he had said that he had not had any contact with mental health services and had no history of self-harm. When he later told her that he had recently taken an overdose of 500 paracetamol tablets combined with a bottle of vodka she did not amend this information. She noted that she would see him again in two weeks and

would refer him to the GP for consideration of antidepressants. He died before the next appointment with her. He did not have a further GP appointment and there is no record of a referral.

33. On the afternoon of 18 March, the man moved to one of cells on the houseblock used for prisoners in their induction period. Entries in his ACCT document over the following days note that he interacted well with other prisoners during association periods and got on well with his cellmate. An officer made two entries in his ACCT record on 20 March noting no concerns. She told the investigator that there was nothing about his demeanour that caused her any concern, but understood that he had a number of risk factors that meant it was reasonable for him to be monitored under ACCT procedures.

34. On the afternoon of 21 March, a SO held an ACCT case review. No other member of staff was present. The SO noted that he had spoken to a mental health nurse before the review. The SO told the investigator that it was often difficult to get a member of healthcare staff to attend an ACCT review, and he had asked the nurse to review the man's clinical records and brief him. However, he did not make a note of what the nurse had told him, and when interviewed, he said he could not recall. He said that, at the review, the man told him that he thought he had depression and was waiting for a doctor's appointment. Apart from this, the SO said that he had appeared positive and categorically denied any intention of harming or killing himself. The man had asked for the ACCT to be closed but he told him he was not prepared to do this as he did not know him. He assessed his risk as low and reduced the level of required observations at night to once every two hours and during the day, staff were required to observe him once in the morning, once in the afternoon and once during evening association. The SO set the next ACCT review for 26 March. He did not amend the caremap and there is no record that he reviewed it.

35. The man finished his alcohol detoxification programme on 22 March. A member from the prison's substance misuse team reviewed him that morning and noted that he had no remaining symptoms of alcohol withdrawal.

36. An officer had some further contact with the man over the weekend of 22 and 23 March. She said that he spent most of his time out of his cell mixing with other prisoners. On Sunday 23 March, she noted in his ACCT record that he looked relaxed. She told the investigator that he seemed settled and comfortable in the environment.

Events leading up to the incident

37. Towards the end of March, an officer unlocked the man at 8.00am and he asked if he could go to the library. She took him there later that morning, but the library was closed. He said that it did not matter and he would go the next day.

38. An officer, who had not met the man before, made several entries in his ACCT document that day. The first entry was at 12.30pm when he unlocked him to collect his lunch. The next two entries were about him going to and returning from the chapel for an induction session. He noted no concerns.

39. A prison chaplain told the investigator that the chaplaincy hold induction sessions for new prisoners every Tuesday to explain prison processes and to tell prisoners how to get help for issues such as maintaining contact with their families. Prisoner peer supporters attend to help. The induction session that day started around 2.20pm and lasted about an hour. The chaplain said that he was very quiet during the session although there had been nothing about his demeanour to cause concern. He later learned that he had asked one of the peer supporters to explain family contact procedures and clarify how the prison telephone system worked.

40. The man's cellmate told the investigator that he had arrived on Houseblock 4 a day or two before the man and they had shared a cell for a week. He had told him why he was in prison and that he was upset about the breakdown of his marriage. Despite this, he said that the man had seemed okay and was as happy as could be expected for someone in his situation. He was due to move from the induction cells and moved cells some time during evening association, between around 4.30pm to 6.00pm on 25 March. He said he was shocked when he heard that the man had taken his life, as he had seen no indications that he might do such a thing.

41. An officer said that he and other wing officers were responsible for moving prisoners from the induction cells to make space for new prisoners as they arrived. He had arranged for the man's cellmate to move. He said that if the man had been regarded as high risk and subject to frequent ACCT observations he would not have left him alone. However, he was required to be observed only three times a day and so he considered there was no reason why he could not be left alone for a few hours. He told him that that he would be getting a new cellmate later that evening and, at 6.15pm, wrote in his ACCT document that he had had his evening meal and he had no concerns about him. He did not record in the ACCT document that he was now alone in his cell.

42. At around 7.55pm, an officer took two new prisoners from reception to Houseblock 4, one allocated to share with the man. When he unlocked the cell he saw him hanging from a wooden wall cabinet by a ligature made from a twisted bed sheet. The cabinet was fixed securely to the wall and therefore able to take his weight. His feet were off the ground. He radioed a code blue emergency to indicate a life threatening situation and the control room called an

ambulance as soon as they received the call. He supported the body with one arm but was unable to cut the ligature which was too thick. One of the prisoners he had brought from reception then supported the body while he and the other prisoner untied the ligature, which had multiple knots. They then lowered him to the floor. He could not find a pulse and started chest compressions.

43. A nurse was in Houseblock 1 when she heard the emergency code blue. She responded straight away and checked that the officer was able to continue with chest compressions while she began to prepare emergency equipment. She checked the man with a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). The defibrillator found no shockable rhythm. Other nurses arrived and they gave oxygen and took turns with chest compressions until paramedics arrived at 8.07pm. Paramedics continued emergency treatment but at 8.36pm pronounced him dead.

44. The man had named his mother as his next-of-kin, but when prison staff went that evening to the address he had given, they found the address was a business premises. The next morning prison staff visited the man's wife and informed her of his death. She gave them his mother's address and the staff then went to see his mother and broke the news. The prison contributed towards the cost of the funeral in line with national Prison Service guidance.

45. The prison held a debrief with the staff involved in the response and informed them of the support available from the care team. Staff reviewed all prisoners being managed under ACCT procedures in case they had been affected by the man's death. Staff opened ACCT procedures to observe and support the two prisoners who had helped when he was found hanging and allocated them a double cell together so they could support each other. A member of staff informed the man's former cellmate in person about what had happened and offered him the opportunity to speak to Listeners (prisoners trained by the Samaritans to give confidential emotional support to other prisoners).

46. A post-mortem examination found no evidence of any injuries other than those that would be expected in a case of a death through hanging.

ISSUES

Assessing and managing risk of suicide and self-harm

47. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 74/2011 (Early Days In Custody), both list a number of risk factors and potential triggers for self-harm and suicide. The man had a number of these risks: early days in custody, recent relationship breakdown, impulsiveness, previous self-harm or suicide attempt, being charged with a violent offence or arson and alcohol dependency. It was the first time he had been in prison for many years. PSI 74/2011 requires new prisoners to be interviewed in reception to assess the risk of self-harm and expects all staff to be alert to the increased risk of suicide and self-harm posed by prisoners in those categories and act appropriately to address any concerns, including opening an ACCT if necessary.

48. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. Neither the reception officer nor the reception nurse opened an ACCT. The nurse said that he felt assured with the man's denials of current suicidal thoughts and the way in which he presented. There is no evidence that they considered his risk factors and it is concerning that the SO said that he would assess a prisoner's risk based on his presentation rather than on his known risk factors. A doctor opened an ACCT later that evening as he rightly considered that the risk factors outweighed the man's assurances. We consider that this was a sound judgment but it is a concern that other staff did not identify the risk. We make the following recommendation:

49. None of the staff the investigator spoke to who had contact with the man over the following days considered him to be other than at low risk of suicide and self-harm, despite the range of his risk factors including a very recent serious suicide attempt and the recent violent attack on his estranged wife. These factors alone should have caused concern. Instead, the staff seem to have relied heavily on his protestations that he did not intend to harm himself.

50. As the doctor remarked, people who intend to kill themselves rarely say so. While a prisoner's presentation is obviously important and reveals something of their level of risk, this is only one piece of evidence in judging risk. All risk factors must be considered to ensure that a prisoner's level of risk is judged holistically. He saw the man only to prescribe medication for alcohol detoxification. Had this not been required, it seems unlikely that anyone at Hewell would have opened an ACCT. We are concerned that the doctor was under the impression that he should not give his views about the need for frequent observations and that the man should share a cell, on the ACCT document.

51. This over-reliance on the man's presentation and what he told staff was reflected in the risk assessments at ACCT reviews. It is difficult to understand how, the day after the ACCT was opened, the review assessed his risk as low with the range of evident risk factors present. This in turn led to observations being set at too low a level. PSI 64/2011 requires ACCT reviews to agree the level of risk posed by the prisoner to themselves, taking into consideration all available sources of information and it is not clear that this was done.

52. Both senior officers who held case reviews said that they would have ended ACCT procedures if they had known the man better. Neither appears to have taken into account that the actions identified in his caremap had not been completed. Reviews should assess progress against the caremap and update them as necessary. An ACCT should not be closed until all agreed actions of the caremap have been completed.

53. On 21 March, a SO held an ACCT case review with no other member of staff present. He said that a nurse had given him advice before the review based on a review of the man's clinical records. The SO said that it was often difficult to find a member of healthcare staff to attend a review. It is an important aspect of ACCT reviews that those responsible for a prisoner's care attend in person if possible and it is more likely that the delay in him seeing a GP would have been identified and resolved had someone from the healthcare team been present.

54. PSI 64/2011 states that ACCT case reviews must be multi-disciplinary where possible. It is mandatory that a member of healthcare staff attend at least the first ACCT case review and where there are ongoing healthcare issues, particularly relating to mental health, we would expect consistent healthcare attendance at further reviews. Whether or not reviews are multi-disciplinary, it is implicit that ACCT reviews, which are based on teamwork, are not held by just one member of staff and this is poor practice. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

- **Reception and first night staff should consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, and open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**
- **All staff should have a clear understanding of the need to record relevant information in ACCT documents.**
- **Case reviews should be multidisciplinary, attended by all relevant people involved in a prisoner's care and assess the level of risk taking into account all risk factors. Levels of observations should reflect this risk.**
- **Case managers should review progress against caremaps at each review.**

Decision to move the man's cellmate

55. The man and his cellmate shared one of the induction cells. On 25 March, his cellmate moved to another cell sometime between 4.30pm and 6.00pm. An officer believed that as the man would be getting a new cellmate later in the evening, there was no problem leaving him alone in his cell for an hour or two until then. He reasoned that the man was on a low frequency of ACCT observations and was regarded as low risk.

56. As noted, we have serious concerns about the level of assessed risk but understand that an officer acted on the information available to him. However, the man was being managed under ACCT procedures and therefore regarded as at some risk of suicide and self-harm. When the officer made his final entry in the man's ACCT at 6.15pm, he did not note that he was then the sole occupant of the cell and he did not record that he had considered the change in circumstances. He was satisfied that it would be reasonable to leave him alone in the cell until a new cellmate arrived that evening.

57. We accept that there will inevitably be occasions when prisoners at risk, who usually share a cell, are left alone in their cells. However, where possible, this should be avoided. The cellmate could have moved his possessions to his new cell but stayed in the cell with the man until a new cellmate arrived. The officer could also have asked for advice about whether the observations needed to be increased while he was alone in the cell. We make the following recommendations:

    The Governor should ensure that, where possible, prisoners assessed as at risk of suicide and self-harm, who usually share cells, are not left alone for extended periods without a documented review of the risk and a consideration of other options to help protect the prisoner.

Clinical care

58. Overall, the clinical reviewer found the clinical care the man received at Hewell was equivalent to that he would have expected to receive in the community. However, he noted some areas for improvement, including that there was no record that healthcare staff had made any attempt to obtain his community health records. This should be done routinely but it was all the more important because of his history of alcohol abuse and his recent hospitalisation after a serious suicide attempt. Prison Service Order 3050 – Continuity of Healthcare, requires that efforts should be made to retrieve any information required from the prisoner's GP or other relevant service the prisoner has been in contact with to inform the continuity of clinical care in prison. We make the following recommendation:

    The Head of Healthcare should ensure that staff routinely request GP records and other relevant clinical records for newly arrived prisoners to ensure continuity of healthcare.

59. The clinical reviewer found some contradictions in the mental health assessment carried out by a nurse on 18 March. The nurse's record of this consultation included that the man had had no mental health support through either primary or secondary care services and that he had no history of self-harm or current intent to harm himself. However, later in the assessment the nurse recorded that he had recently taken 500 paracetamol tablets with a bottle of vodka after the break up of his marriage. Some of the information was available in his medical record. It appears that the nurse relied on what he told her and recorded his answers, but did not then go back to correct them, when it became clear that some of the earlier information was incorrect. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff complete mental health assessments accurately taking into account all the available information.

60. The clinical reviewer noted that the nurse's plan on 18 March was to refer the man to a prison doctor to consider whether he needed to be prescribed antidepressants. There is no evidence that this referral was made. A GP had not reviewed him by the time of his death. We make the following recommendation:

The Head of Healthcare should ensure that all agreed actions at healthcare consultations are progressed.

RECOMMENDATIONS

1. The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

    - Reception and first night staff should consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, and open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
    - All staff should have a clear understanding of the need to record relevant information in ACCT documents.
    - Case reviews should be multidisciplinary, attended by all relevant people involved in a prisoner's care and assess the level of risk taking into account all risk factors. Levels of observations should reflect this risk.
    - Case managers should review progress against caremaps at each review.

2. The Governor should ensure that, where possible, prisoners assessed as at risk of suicide and self-harm, who usually share cells, are not left alone for extended periods without a documented review of the risk and a consideration of other options to help protect the prisoner.

3. The Head of Healthcare should ensure that staff routinely request GP records and other relevant clinical records for newly arrived prisoners to ensure continuity of healthcare

4. The Head of Healthcare should ensure that healthcare staff complete mental health assessments accurately taking into account all the available information.

5. The Head of Healthcare should ensure that all agreed actions at healthcare consultations are progressed.

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 should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular: · Reception and first night staff should consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, and open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent. · · All staff should have a clear understanding of the need to record relevant information in ACCT documents. · · Case reviews should be multidisciplinary, attended by all relevant people involved in a prisoner's care and assess the level of risk taking into account all risk factors. Levels of observations should reflect this risk. · · Case managers should review progress against caremaps at each review	Accepted	• The local Safer Custody policy will be fully reviewed to ensure that it includes current information on all elements concerning the management of prisoners at-risk of suicide and/or self-harm. • Further Safer custody training will be delivered to all staff working in reception and first night - both operational and healthcare. • Local case manager training will be delivered, targeting quality of reviews and ensuring a multi disciplinary approach, analysis of risk and recording appropriate observations to reflect risk level and CAREMAP management and reviews. • Further training will be updated to ensure that the importance of recording key information with ACCTs is relayed to staff working within the Prison Environment.	· 31 January 2015 – Head of Safety · · 31 December 2014 - Head of Safety · · 31 December 2014 - Head of Safety · December 1/1/14- Head of Safety	
2	The Governor should ensure that, where possible, prisoners assessed as at risk of suicide and self-harm, who usually share cells,	Accepted	• Guidance will be issued within the local Safer Custody Policy, to advise staff where a prisoner is identified of being a heightened level of risk staff	31 January 2015 – Head of Safety	

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	are not left alone for extended periods without a documented review of the risk and a consideration of other options to help protect the prisoner.		will need to ensure appropriate support is in place including when a cell mate is absent for extended periods. • The forthcoming local case manager training in December 2014 will address the risk of prisoners being left alone and consideration of other options available. • Management checks will be amended to include above recommendation.	December 31st 2014 - Head of Safety December 1st 2014- Head of Safety	
3	The Head of Healthcare should ensure that staff routinely request GP records and other relevant clinical records for newly arrived prisoners to ensure continuity of healthcare	Accepted	A memo to all healthcare staff issued in October 2014 addressed the need for: • The reception nurse to obtain consent to gain the GP information. • Administrative support (Band 2) to ensure that all GP and mental health information is requested for prisoners received in the previous 24 hours. • An action point has been added to the secondary health screen assessment to remind staff of the above requirements.	Completed Head of Healthcare	
4	The Head of Healthcare should ensure that healthcare staff complete mental health assessments accurately taking into account all		All healthcare staff have been reminded of the need to fully complete mental health assessments relying on relevant information available from previous SystmOne	Completed Head of Healthcare	

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	the available information		(electronic healthcare) records and any community mental health records. This was reinforced at a staff meeting and in a staff memo in October 2014.		
5	The Head of Healthcare should ensure that all agreed actions at healthcare consultations are progressed.		All healthcare staff have been reminded that where any assessments require further action to be taken, that the completing nurse takes responsibility for ensuring that they are progressed. This was reinforced at a staff meeting and in a staff memo in October 2014.	Completed Head of Healthcare.	