PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Highpoint in April 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 Highpoint in April 2013. He was 25 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was conducted. The prison cooperated fully with the investigation.

The man was released from a prison sentence in September 2010 but was twice recalled to prison after breaching his licence conditions. After being recalled in October 2011 he transferred to Highpoint on 22 March 2012. He found it difficult to control his anger, had thoughts of self-harm and his moods fluctuated. He had relationship difficulties and missed his children. He was briefly subject to suicide prevention measures, but these were closed before support was put in place. From October 2012, he was supported by a mental health worker for a month, but this stopped when his allocated worker left the prison. No one took over his care and he was discharged from the mental health team without being seen.

The investigation has identified a number of significant weaknesses in the management of suicide prevention measures and mental health services at Highpoint which need improvement. Although it appears that it would have been too late to save the man, officers should have checked him twice, at a roll check and when his cell was unlocked, but this was not done. Staff failure to check for vital signs when unlocking cells is an issue that has arisen in a number of other investigations at Highpoint and is one which requires a robust management response. When he was finally discovered, he had been dead for some time, which meant that staff efforts to resuscitate him were unfortunately futile.

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 2013**

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SUMMARY

1. The man was recalled to prison in October 2011, charged with criminal damage, breach of a restraining order, assault, harassment and burglary. On 24 February 2012, he was sentenced to three years imprisonment. In March 2012 he transferred to Highpoint South. On 2 October he told the prison psychologist that he had attempted to hang himself the previous weekend, but was stopped by another prisoner. Suicide and self-harm prevention procedures (known as Assessment, Care in Custody and Teamwork or ACCT) were begun, but ended three days later when it was decided he was no longer a risk. He was referred for a mental health assessment, but did not turn up for two appointments. The reasons are not recorded.

2. The man was referred to the mental health team again on 24 October. The next day, a mental health nurse noted that he had relationship difficulties. He was to receive regular mental health support and was prescribed antidepressant medication. He saw the mental health nurse, his key worker, on 25 October, 30 October and 22 November. His mental health key worker then left the prison but no cover was arranged, so he had no contact with the mental health team for the next four months until he was discharged from the mental health caseload on 21 March 2013, without being seen. He was still taking antidepressants.

3. During March, officers noted that the man was sometimes upset because of ongoing relationship difficulties and problems contacting his son. On 3 April, another prisoner told him that his ex-partner had started a new relationship. He was upset by this news but his friends on the wing said that his mood quickly improved.

4. A few days later, the night officer who conducted the morning roll check at around 6.30am did not check the man's cell. At 8.15am, an officer unlocked his cell but did not look through the observation panel or speak to him. At about 8.30am, another prisoner discovered him hanging in his cell. The alarm was raised and prison and healthcare staff attended. His body was cold and stiff. Although rigor mortis was apparent, indicating that resuscitation attempts would be futile, cardiopulmonary resuscitation (CPR) continued until paramedics arrived. At 8.41am the prison doctor and the paramedics pronounced him dead.

5. The investigation found failings in ACCT procedures and mental health services at Highpoint. It is extremely concerning that the man was not properly checked on the morning he died, an issue that we have brought to the Governor's attention in a previous investigation. Staff should not have attempted resuscitation, as there were clear signs of rigor mortis.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Highpoint to inform them of the investigation and asking anyone who had relevant information to contact him. No one responded.

7. The investigator informed HM Coroner for Suffolk of the investigation. The Coroner provided a copy of the post-mortem report. A copy of this investigation report has been sent to the Coroner.

8. The local PCT appointed a clinical reviewer to review the man's clinical care in prison.

9. On 9 April, the investigator visited the prison. He met the Governor and collected the man's prison records. On 8 and 9 May, he and the clinical reviewer interviewed eight staff and two prisoners A third prisoner the investigator asked to speak to declined to be interviewed.

10. One of the Ombudsman's family liaison officers (FLO) spoke to the man's mother and explained the investigation process. She wanted to know more about her son's time in prison and how he was able to take his own life.

11. The man's mother received a copy of the draft report. She did not raise any further issues or comments on the factual accuracy of this report.

HMP HIGHPOINT

12. HMP Highpoint is on two sites, Highpoint (South) which was the original HMP Highpoint, and Highpoint (North), which was previously known as HMP Edmunds Hill. Highpoint is a prison for category C adult male prisoners. (Category C prisoners are those who are not judged ready for open conditions but who are unlikely to escape and do not require high security.) The man lived at the south site. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

13. The last report published report on Highpoint by HM Inspectorate of Prisons (HMIP) followed an inspection in September 2012. The report found that, while there were some problems, the prison largely provided a decent and safe environment. Inspectors noted the number of prisoners subject to ACCT was proportionate to the population and initial screening arrangements were good. However too few staff had been trained in revised ACCT procedures.

14. The Inspectorate found that prisoners were negative about both the quality of and access to health services, although the Inspectorate found access was good. Inspectors noted that a high proportion of prisoners did not attend healthcare appointments. The Inspectorate described mental health services as reasonable.

Independent Monitoring Board

15. Each prison in England and Wales 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 published report the IMB had serious concerns about the management of healthcare, which had just transferred to a new provider. They hoped that new systems would help improve provision.

Assessment Care in Custody and Teamwork

16. 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 the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Previous deaths at HMP Highpoint

17. The man's death was the third death at Highpoint (South) since 2010. Following the death of the first prisoner, we found that prisoners' welfare was

not checked when cells were unlocked in the morning. We have commented on this matter again in this report, and understand that it has been highlighted once more after the death of a prisoner in August 2013 at Highpoint. We have also recommended that the Head of Healthcare should introduce an effective system for following up missed appointments and we repeat this recommendation.

KEY EVENTS

18. In May 2008 the man was sentenced to five years and six months imprisonment. He was released on licence in September 2010, but breached his licence conditions and was recalled to prison on 22 June 2011. In reception at HMP Wormwood Scrubs, he was assessed as having anger issues, paranoia and it was recorded that he had been under the care of the community mental health team as a child. He was released on licence again one month later.

19. In October 2011, his licence was revoked again because he had breached a restraining order against his partner, committed further offences of criminal damage, assault (against his partner), harassment and burglary. He was arrested on 10 October 2011 and taken to HMP Wormwood Scrubs.

20. The man told officers in reception that he would only share a cell with someone of his own racial group, so he was assessed as high risk to share a cell. The reception nurse recorded that he had been homeless for the previous two months, but he was fit and well, had no mental health concerns or thoughts of self-harm. He told the nurse that he did not take drugs or abuse alcohol and was not registered with a GP.

21. On 20 February, the man's offender manager interviewed him for a pre-sentence report. He told her that he was hearing voices, felt paranoid and had anger management issues. He said he felt suicidal and described his emotions as up and down. He said he had family issues and that he would hurt someone if he was released from prison.

22. On 24 February 2012, the man was sentenced to three years in prison. He remained at Wormwood Scrubs for another month. Officers described him as seeming low for a few days, but no other concerns were recorded.

HMP Highpoint

23. The man transferred to HMP Highpoint on 22 March 2012. No concerns were recorded at his reception screening. At his initial health screen, the nurse recorded that he was fit and well, and had no thoughts of suicide or self-harm. He described himself as a light drinker and said he smoked cannabis weekly. The officer who completed his first night in custody paperwork, noted that he smoked, could read and write and had no language problems. He was still considered too high a risk to share a cell.

24. On 1 April, an officer recorded in the man's electronic case notes that he was an angry man who was sometimes rude. He told the officer that he had family issues which he intended to resolve when he was released from prison. The officer reminded him to submit his application for the Thinking Skills Programme, a course which was identified to help address aspects of his offending behaviour.

25. On 14 April, an officer introduced himself to the man as his personal officer[1]. He recorded in his case notes that he was polite and well behaved. On 20 June, he moved to another wing and was assessed for the Thinking Skills Programme. The man's new personal officer recorded in his case notes on 13 July that he was quiet and respectful and employed full-time.

26. The man was involved in a fight with another prisoner on 19 July. He was found guilty at a disciplinary hearing and a punishment of loss of earnings was suspended for three months.

27. The man had his first session with a psychologist, who was his one-to-one facilitator for the Thinking Skills Programme. She described him as calm, but troubled and withdrawn. He said he was having problems with his family and his relationship, so he felt that he had nothing to live for. However, she told the investigator that she did not consider his mood to be down. She was confident that the Thinking Skills Programme would help him, and suggested that he would also benefit from completing the prison CALM[2] programme.

October 2012

28. At a Thinking Skills Programme session on 2 October, the man told the psychologist that he had tried to kill himself at the weekend (29-30 September) by tying a ligature around his neck but another prisoner had stopped him. He had been upset because it was his ex-partner's birthday, and said he would be better off dead. He said he would have no one when he was released. She recorded that he appeared unstable and distressed and opened an ACCT. He asked to be referred to the mental health team. Officers searched his cell and a ligature was found.

29. The man told the ACCT assessor that he was not eating or sleeping well and had lost weight. He said he did not want to die and had recently re-established contact with his five year old daughter from a previous relationship, which had had a positive effect on him. At the ACCT case review that afternoon, he said that he had a poor relationship with his family and ex-partner, who had custody of his son. He was worried about his son's health. He was frustrated and depressed and described his mood as fluctuating up and down. The psychologist agreed to contact his offender manager to find out about his release arrangements, and he was referred to the mental health team. The chaplaincy were also asked to visit him to offer support. His risk of self-harm was recorded as raised and he was to be checked hourly. At the end of the ACCT review, he told the staff that he felt supported.

30. On 3 October, the psychologist told the man that she had spoken to his offender manager, who said that he would be supported when he was released from prison. She offered to help him write to social services about access to

[1] A personal officer should develop a supportive relationship with a prisoner and act as the first point of contact for any issues or concerns.
[2] CALM (Controlling Anger and Learning to Manage it) is an emotional management programme designed for those whose offending behaviour is linked to their emotions.

his son after he was released. She said his response was positive and appeared to be content with the information.

31. The next day, the man's offender supervisor met with him, then emailed the mental health team saying that he needed a psychiatric assessment because he was struggling to cope with his course and his family problems. The mental health team made appointments for him to be seen on 5 October and 16 October, but he did not attend either appointment. There is no recorded reason for him missing the appointments or any evidence that anyone spoke to him about why he missed them.

32. The man was described as positive at the next case review on 5 October, which was attended by the psychologist, a SO and an officer. It was agreed that his level of risk was low and his ACCT was closed. No one from the healthcare team was at the review and he had still not been seen or assessed by the mental health team, or visited by a chaplain as specified in his ACCT caremap.

33. At an ACCT post-closure review on 17 October, a Senior Officer (SO) recorded that there were no issues of concern about the man, and the ACCT should remain closed. He had still not had a mental health assessment, or been seen by the chaplaincy.

34. On 24 October, the psychologist referred the man to the mental health team, because some of the matters that they had discussed in the Thinking Skills Programme which he had found difficult to manage. He told her that he was disappointed that healthcare staff had not responded to an application he had submitted. (We were unable to find any record of this application.)

35. A community psychiatric nurse met the man on 25 October to carry out a mental health review. He recorded in his medical record that the man had recently been monitored under ACCT procedures and was struggling to cope with feelings prompted by the Thinking Skills Programme. He said he had feelings of hopelessness which were caused by the relationship problems with his ex-partner and family. He was angry and felt withdrawn and isolated. The nurse drew up the following care plan:

    - He was to gain employment to use his time more productively and integrate more with other prisoners;
    - The nurse would contact his offender manager to establish what support would be in place after release;
    - The nurse would suggest to the GP that he be prescribed antidepressant medication (mirtazapine 15mg) to be reviewed in three months;
    - To review him on Monday morning (29 October).
    - Inform him of the actions listed on the care plan.

36. The next day, 26 October, the nurse contacted the man's offender manager to discuss his resettlement plans. He relayed the details, including planned accommodation after release to the man, who said he was happy about the arrangements. He was given a cleaner's job in accordance with his care plan.

The prison doctor saw him and prescribed mirtazapine 15mg for three months. The doctor assessed that it was safe to give him a week's supply at a time to keep in his cell.

37. The community psychiatric nurse met the man again on 30 October. The nurse said he appeared to be doing well and was managing his feelings better. He said that he intended to write to his offender manager so he could start to address some of his issues. The nurse explained that he would soon be leaving the prison for a few months and checked that he knew how to access the mental health services in his absence if he needed to.

November 2012

38. The community psychiatric nurse assessed the man on 22 November, and recorded that he appeared to be managing well. Officers were positive about his work as a cleaner. He was taking his medication and he said it had helped to lift his low mood. The nurse planned that he would be reviewed by another member of the mental health team again on 26 November as he would be away from the prison for several months from 23 November 2012. The nurse had handed over his caseload to others in the mental health team.

39. On 23 November, the man attended a Thinking Skills Programme review with the psychologist and his offender supervisor. His offender manager contributed via a telephone conference call. He had finished the programme on 2 November and it was agreed that he had benefited from the course. It was suggested that he would benefit from completing the CALM course to develop his emotional management. He was encouraged to apply for enhanced status under the incentives and earned privileges scheme.

40. An officer introduced himself to the man on 27 November as his new personal officer. He recorded that the man had completed the Thinking Skills Programme but had refused to participate with a Healthy Relationship Programme[3] assessment on 21 November.

December 2012

41. On 2 December, the man was given enhanced status under the incentives and earning privileges scheme and, on 15 December, he moved to the cleaners' landing with an enhanced regime. An officer recorded in his case notes that he was now on an enhanced regime and was working well as part of the cleaning party. The man's friend moved to the cell next door to him shortly afterwards.

January 2013

42. Another officer took over as the man's personal officer on 3 January 2013. She recorded in his case notes that he was working well on the unit as a cleaner and was always keen to undertake additional jobs. She had no concerns about

[3] The Healthy Relationships Programme is designed for men with a prior history of violent or abusive domestic behaviour who are viewed as a risk for repeated violent behaviour within relationships or a domestic setting.

him. She made further positive remarks about his hard work on 14 January, recording that he was always helpful and managed the laundry well. He told the officer that he was due to have a legal visit soon and he was trying to arrange access to his son which was difficult due to his relationship with his ex-partner.

February – March 2013

43. On 6 February, the mental health team reviewed the patients on the community psychiatric nurse's caseload, none of whom had been seen during his absence, including the man. They agreed to send a letter to each prisoner to ask if they still wanted to receive support from the mental health team. A mental health nurse wrote to him on 6 February.

44. On 10 February, the man's personal officer recorded in his case notes that he continued to work hard on the unit and caused no concerns. He had received a letter from his solicitors and some photographs of his daughter.

45. On 28 February, the man replied to the mental health nurse's letter of 6 February to say that he still wanted to receive support from the mental health team. Two appointments were made for him on 28 February and 7 March, but he did not attend either of them. The nurse wrote again to him on 7 March asking him if he wanted to contact the mental health team. He was given 14 days to respond and if he did not the team would assume he no longer needed mental health support. There is no record of a reply being received.

46. On 21 March, the man was formally discharged from the mental health team caseload. The mental health nurse told the investigator that he did not meet him, but he knew he was a wing cleaner and expected officers to pass on any concerns to healthcare staff. One of the man's friend said that he talked about the community psychiatric nurse a lot after he left the prison. He said he told him that he had wanted to see the nurse but officers told him that he was not available.

47. On 24 March, the man's personal officer recorded that the man had had a difficult week. He was running the laundry when one of the dryers stopped working, which delayed prisoners' laundry and caused a lot of complaints. He was very anxious about this, as well as his ongoing relationship difficulties, and problems with getting access to his son. He was given a different role to reduce the pressure he felt in his job. His personal officer spoke to him a lot and he said he was being supported by his friend, who he had known for a long time.

48. The man's personal officer thought that he was waiting for an appointment with the mental health team, and he asked her to chase them on his behalf. A nurse told the officer that the man should book an appointment. The officer then told him to make an application to see the mental health team. There was no record of this in his medical record but the officer told the investigator that she did not know if he had been seen by the mental health team.

April 2013

49. On Wednesday 3 April, the man told his personal officer that he had received a letter from his solicitor, which was not good news. Although he was initially upset, by the end of the conversation, she said he was laughing and joking with her. She did not see him again because she was on leave, but did not think he was at risk of self-harm and was not worried about him.

50. On 3 April, another prisoner told the man that his ex-partner was in a new relationship. The man's friend told the investigator that he was upset about this and lots of prisoners visited him in his cell to try to cheer him up.

51. The man wrote two letters dated 4 April, which were not posted but found in his cell after his death. One letter was addressed to the mother of his son, and he apologised for his past behaviour towards her. He said he missed his son and felt worthless, but did not indicate any intention to kill himself. The second letter was addressed to a friend, and he wrote about his plans to live near his daughter after he was released. He said he was on antidepressants but had reduced the dose because he was getting better. (His prescription had not been reviewed or altered by healthcare staff since October 2012.)

Friday 5 April – Sunday 7 April

52. Other prisoners told the investigator that the man's mood appeared to have improved by Friday 5 April. They said he was laughing and joking on the wing as normal.

53. The man's friend said he spent some time with him on Saturday 6 April. He described him as a bit depressed but thought that it was to be expected given the news about his ex-partner. He reminded him to take his medication because it could help him sleep better. On Sunday 7 April, he said he drank tea with him in his cell and then visited another prisoner.

54. At weekends, prisoners are locked in their cells between 4.30pm to 5.00pm. Just before he was locked up on Sunday evening, the man's friend said the man was smiling, laughing and joking on the wing. His friend lent him his stereo for the night and said he would see him in the morning so they could go to the gym together. He reminded the man to take his medication. He said he was not worried about him.

55. An officer was on duty at the weekend, and recalled seeing the man on Sunday afternoon working outside the staff centre office sorting out the laundry bags. He said he had no concerns about him.

56. An operational support grade (OSG) started an evening roll check around 8.40pm and signed to say it was correct at 9.00pm. When interviewed by the police after the man's death, he said there were no issues during the check. He told the investigator that a member of staff checked that his cell door was locked that evening, but no one looked through his observation panel.

Morning of the incident

57. The OSG signed to say he had completed the morning roll check at 6.45am. However, he subsequently admitted to the prison and police that he did not check any cells during the morning check.

58. An officer arrived for duty on the wing at around 7.30am and the OSG handed over to her then left the prison. There is no requirement for a roll check to be completed by the in-coming member of staff.

59. An officer unlocked the man's cell that morning shortly after 8.15am. He said he did not look through the observation panel or speak to the man before moving on to the next cell.

60. The man's friend said that when his cell was unlocked, the officer did not look through his observation panel either. Shortly afterwards, he left his cell and collected a magazine from another spur. He said he returned to his cell to finish his cup of tea, sorted out his gym clothing and then went next door to collect the man. He looked through the observation panel on his door, and said he appeared to be looking out of the window at the back of the cell. He opened the door and walked up to him and called his name, but he did not respond. He then realised that he was hanging from the window with a dressing gown cord around his neck.

61. He ran out of the cell and shouted for help. Two other prisoners ran into the cell and supported the weight of the man's body, which was described as cold and stiff. Another prisoner untied the dressing gown cord from the window and the prisoners moved the man to the cell floor.

62. When the man was found, a prisoner on the landing pressed the general alarm button, which was recorded at 8.32am. Officers ran towards the cell. When they went into the cell, the man was on the floor with a clear mark around his neck. An officer immediately radioed a Code Blue[4] emergency (recorded at 8.33am). An ambulance was called at 8.34am. The prisoners left the cell and staff took over.

63. Two officers were first aid trained. They checked the man's vital signs, but found none. His lips were blue and his body was cold and rigid. They started cardiopulmonary resuscitation[5] (CPR) with one officer doing chest compressions. Another officer tried to open the man's mouth to give rescue breaths, but his jaw was locked. A SO assisted with chest compressions.

64. CPR continued until two nurses arrived at about 8.38am, and took over the resuscitation attempt using an ambu-bag[6] and a defibrillator. The man remained unresponsive. The first response paramedics arrived at the prison gate at 8.38am followed by an ambulance at 8.41am. Both got to the cell about

[4] A code blue indicates a life-threatening emergency when a prisoner has breathing difficulties.
[5] Cardiopulmonary resuscitation is an emergency procedure using chest compressions and rescue breaths to keep blood and oxygen circulating in the body.
[6] An Ambu-bag is a bag connected to a mask and is used to breathe for a patient when the patient is not breathing on his own.

two minutes after they arrived at the prison. The prison doctor arrived and examined the man. At 8.41am, the paramedics and doctor agreed that he had died.

Support for staff

65. Residential manager held a hot debrief at 2.00pm to support the staff involved in the emergency response. Staff were offered the help of the care team.

Support for prisoners

66. Notices posted in the prison informed prisoners about the man's death and reminded them of the support available. All prisoners subject to suicide and self-harm monitoring procedures were reviewed in case they had been adversely affected by his death. The man's friend received specific ongoing support. The Samaritans and a chaplain were on the wing all day on 8 April to support prisoners.

Family liaison

67. The prison appointed a family liaison officer (FLO) at 9.35am. The man had listed his cousin in London as his next of kin. The FLO, an operational manager and a chaplain were in London on other prison duties at the time. They went to the address listed for the man's cousin, but she no longer lived there so they contacted the police for her new address. The police eventually provided another London address, but there was no one there and no answer from the listed telephone number. The police said they would try the address again later in the day.

68. The FLO contacted the prison safer custody team who checked prison documentation to see if any other next of kin contact details could be found. The man's step-father in London had been listed as his next of kin when he was subject to ACCT procedures in October 2012. The prison staff then visited the address they had for the step-father around 3.30pm, but neighbours told them that he no longer lived there. They then returned to the man's cousin's home. No one was there and a neighbour eventually told the FLO that his cousin had moved. There was still no answer on her telephone, and the police could not trace her. The FLO returned to the prison.

69. By the next morning (9 April), the prison had found the man's mother's telephone number, but did not have her home address. An Operational Manager agreed that the FLO should telephone the man's mother to break the news of her son's death. The FLO, an operational manager and a chaplain visited the man's mother that afternoon to explain the circumstances. The man's step-father was with her.

70. The prison offered to pay reasonable funeral expenses in line with national guidance. The funeral took place on Friday 26 April. A memorial service in the prison was held the same day.

Post-mortem report

71. The cause of death recorded in the post-mortem report was hanging.

ISSUES

Missed healthcare appointments

72. The man missed four appointments with the mental health team at Highpoint. Healthcare staff explained to the investigator that all prisoners attending for healthcare appointments have an appointment slip delivered to them under the cell door. Officers can see which prisoners have a healthcare appointment on a central computer system. A prisoner cannot be made to attend a healthcare appointment, but we note that HM Inspectorate of Prisons reported at their last inspection of Highpoint that a high number of appointments were missed and recommended that the prison work to reduce this.

73. We are concerned that the man's non-attendance was not followed up, especially as it initially related to his risk of self-harm, then his unaddressed mental health needs. There is nothing in the records to show why he missed appointments, or any indication that anyone discussed this with him to find out whether he had chosen not to go. It does not appear that he was aware of some of his appointments, as on 24 March he asked his personal officer to chase the mental health team on his behalf. We have already drawn the issue of missed appointments to the Head of Healthcare's attention following a death in custody in February 2013, and repeat this recommendation:

    The Head of Healthcare should ensure that the system for informing prisoners of healthcare appointments operates effectively and that prisoners' non-attendance is followed up with reasons recorded.

<u>Mental Health Services</u>

74. Prison Service Instruction (PSI) 64/2011- Safer Custody requires that when a prisoner is identified as at risk of suicide or self-harm, staff should "Inform Healthcare, including the mental health in-reach team where appropriate, so that the opening of the ACCT Plan can be noted in the clinical record".

75. The man was referred to the primary mental health services on 4 October 2012, when the ACCT document was opened. The mental health team sent two appointments to see him, but he did not attend the appointments. No one from the team went to see him in person. The clinical reviewer considers that healthcare staff should prioritise prisoners who are considered at risk of suicide or self-harm and we agree. We do not consider that the onus should be on the prisoner to respond, especially when it cannot be guaranteed that the appointments were received. We make the following recommendation:

    The Head of Healthcare should ensure that the prisoners referred to the mental health team identified as at risk of suicide or self-harm are seen with appropriate urgency.

76. The man was seen by a community psychiatric nurse on 25 October after a further referral from a psychologist. The nurse set up a care plan. He was seen by the prison GP and was prescribed antidepressant medication. The

nurse then saw him on 30 October and 22 November. He was not contacted by anyone from the mental health team until 6 February 2013, some five months later and then only in writing, when the mental health team realised that they had not reviewed a number of prisoners from the nurse's caseload.

77. There were no formal arrangements to cover the nurse's planned absence. As a result over two months passed before several prisoners were offered the opportunity to receive planned mental health support. The mental health team did not take responsibility for assessing those prisoners, but wrote to the prisoners and relied on the prisoners' account of their own mental health needs to determine if they needed support. The nurse had assessed that the man needed ongoing mental health support and planned for him to be seen a few days after his last intervention. The mental health team did not cover the nurse's absence adequately and this compromised his mental health care. To compound this, he was discharged from the mental health team caseload without any assessment of his mental health needs.

78. We agree with the clinical reviewer that there should be a complete review of the mental health pathway at HMP Highpoint to ensure that the prisoners' mental health needs are adequately met. We make the following recommendation:

The Head of Healthcare should ensure that arrangements for the delivery of mental health services are comprehensively reviewed to ensure prisoners receive appropriate mental health support, according to their assessed needs.

Antidepressant medication

79. A doctor prescribed the man antidepressant medication from 25 October 2012 for three months. He continued to take medication until his death nearly five months later. His medication was not reviewed by a medical professional in that time. His prescription chart was updated every 28 days and showed that he still collected his (in-possession) antidepressant medication weekly.

80. We agree with the clinical reviewer that the prescribing doctor has a responsibility to review the ongoing use of prescribed medication, yet there is no evidence that these reviews took place. This is in conflict to the National Institute for Clinical Excellence (NICE) guidelines for the treatment and management of depression. These state:

> "for people started on anti-depressants who are not considered to be at increased risk of suicide, normally see them after 2 weeks. See them regularly thereafter, for examples at intervals of 2 to 4 weeks in the first 3 months, and then at longer intervals if the response is good".

81. We therefore make the following recommendation:

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

Assessment and management of risk of suicide and self-harm

82. PSI 64/2011- Safer Custody outlines the purpose of an ACCT which includes: identifying the prisoner's most pressing needs and how to address them, the level of risk taking into account all sources of information, agreeing how the prisoner will be supported, considering and recording progress against the initial caremap and considering whether the prisoner exhibits any additional needs which may require the caremap to be updated. The man reported that he had attempted to hang himself over the weekend of 29 to 30 September and an appropriate decision was taken to monitor and support him though ACCT procedures. However, the ACCT remained open for just three days, and we have a number of concerns about the management of the ACCT procedures.

83. The PSI requires that ACCT case reviews are held by a multidisciplinary team which adds to the effectiveness and continuity of the ACCT process. It states that the first case review should be attended by 'the Residential Manager, or equivalent and/or the Case Manager (if different), the Assessor, whenever possible, a member of staff who knows the prisoner e.g. wing officer, the person who raised the initial concern, healthcare, and any other member of staff who will has or will have contact with the at-risk prisoner and who can contribute to their support and care'.

84. No one from the mental health team attended or contributed to either of the man's ACCT reviews despite the fact it was identified that he might benefit from mental health team support. He was supposed to be referred to the mental health team when the ACCT was opened, but he was not assessed until the psychologist contacted the mental health team two weeks after his ACCT had been closed. As his mental health was identified as a risk factor that needed to be addressed, the mental health team should have been involved in his ACCT.

85. The PSI 64/2011 notes that the ACCT must only be closed once all the caremap actions have been completed and the case review team judges that it is safe to do so in that the risk posed by the prisoner has reduced.

86. At the man's second case review on 5 October, the SO closed the ACCT, but not all the caremap actions were completed. He had not been seen or assessed by anyone from the mental health team, or visited by a member of the chaplaincy, two of his caremap actions. The chaplain told the investigator that no one from the chaplaincy had been asked to support him.

87. At the closing case review, the case manager should be satisfied that the prisoner's problems have been resolved and that all caremap actions have been completed. The man's ACCT was closed just three days after it was opened, after he had reported trying to hang himself, indicating a high level of risk. His mental health had still not been assessed and he had not seen a member of the chaplaincy for support. Both of these services could have

identified and provided valuable feedback about his level of risk which could have been used to determine the right type and duration of support he needed. A post-closure review was held on 17 October which should have reviewed the caremap and progress made but this did not appear to have been done. We make the following recommendation:

The Governor should ensure that case managers follow the guidance in PSI 64/2011, ensure multidisciplinary attendance at case reviews, and do not close an ACCT plan until the actions in the caremap have been achieved.

Roll check and unlock procedures

88. Highpoint's local instructions requires that night patrol staff conduct two routine roll checks, one at the beginning of the night shift at 9.00pm, and the other when day staff start duty, at about 6.30am. The instruction notes that roll checks are conducted to ensure the prison roll is correct and that every offender is in the correct cell (if necessary by seeing their face). The procedure makes no reference to checking prisoners' welfare.

89. Due to a technical fault, resulting in the corruption of the records, the prison was unable to provide the investigator with CCTV footage for the period 7 to 8 April. An OSG reviewed the CCTV footage before it was corrupted. She told the investigator that the CCTV showed that the officer completed the evening roll check correctly. He checked the doors were locked and looked through each observation panel. The CCTV showed that when the OSG started duty at 8.40pm, he only checked that cell doors were locked and did not look through the observation panels. He made no more checks during the night and did not complete the morning roll check at 6.30am as he was required to do, and as he had signed to say he had done.

90. The OSG was suspended from duty immediately after the man's death and his actions are subject to prison and police investigations. We cannot know whether, if he had checked at the morning roll check as he should have done, it would have been in time to save the man, who had evidently been dead for some time when he was found at 8.30am.

91. Officers are supposed to look at and make contact with a prisoner through the observation panel before opening a locked cell door. As well as a security precaution, it is supposed to be a check on the prisoner's wellbeing. It ensures that staff rather than other prisoners are the first to deal with any emergency. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

92. An officer did not attempt to get a response from the man when he unlocked his cell at 8.15am. The officer explained that prison staff have a very restricted time frame to unlock prisoners, so he often did not wait to get a response from prisoners. Other officers also said that they did not usually wait to get a response from prisoners before they unlocked their cells.

93. When the man was found, there were signs of rigor mortis, suggesting that he had been dead for some hours. It is not possible to say when he died, but it is a concern that he was not checked when the cell was unlocked. While a check at unlock might not have saved him, it would have ensured he was found by prison staff rather than other prisoners.

94. At the time of the man's death, Highpoint had no local instructions about unlock procedures but officers should have followed national guidance. Prison Service Instruction (PSI) 10/2011, paragraph 2.3 gives further guidance about the responsibility of the unlocking officer:

> "Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

95. We have recently drawn attention to this matter in our investigation into another death at Highpoint in February 2013. We repeat that recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

The emergency response

96. Prisoners who found the man raised the alarm as soon as they saw him hanging in his cell. Other officers responded quickly and began CPR promptly. Healthcare staff arrived quickly and continued CPR. Several prisoners and staff described his body as cold and stiff when he was found.

97. We are surprised that healthcare staff continued with CPR even when there were no signs of life and rigor mortis was present. European Resuscitation Guidelines 2010 state "Resuscitation is inappropriate and should not be provided when there is clear evidence that it would be futile …". Delivering CPR in such circumstances is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that the system for informing prisoners of healthcare appointments operates effectively and that prisoners' non-attendance is followed up with reasons recorded.

2. The Head of Healthcare should ensure that the prisoners referred to the mental health team identified as at risk of suicide or self-harm are seen with appropriate urgency.

3. The Head of Healthcare should ensure that arrangements for the delivery of mental health services are comprehensively reviewed to ensure prisoners receive appropriate mental health support, according to their assessed needs.

4. The Head of Healthcare should ensure in line with NICE guidelines that follow-up appointments are made to review the progress of prisoners prescribed antidepressants.

5. The Governor should ensure that case managers follow the guidance in PSI 64/2011, ensure multidisciplinary attendance at case reviews, and do not close an ACCT plan until the actions in the caremap have been achieved.

6. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

7. The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

ACTION PLAN: The Man – HMP High Point

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that the system for informing prisoners of healthcare appointments operates effectively and that prisoners' non-attendance is followed up with reasons recorded.	Accepted	A new system for delivering appointment details for patients has been implemented. All non-attendees are now followed up and appropriate entries are made in the medical records(SystmOne)	Complete	

2	The Head of Healthcare should ensure that the prisoners referred to the mental health team identified as at risk of suicide or self-harm are seen with appropriate urgency.	Accepted	The Mental Health Service has key performance indicators set; these clearly define the timescales within which a prisoner should be seen. They form an integral part of the contract meeting with Care UK, when indicators are not met exception reporting is required along with the corrective action that will be taken.	Complete	
3	The Head of Healthcare should ensure that arrangements for the delivery of mental health services are comprehensively reviewed to ensure prisoners receive appropriate mental health support, according to their assessed needs.	Accepted	The mental health service at HMP Highpoint is going through a review process at the present time. An overall operations policy is being put in place which includes a mental health pathway. This will then clearly define an offender's care pathway while on the mental health case load.	30/11/2013	

4	The Head of Healthcare should ensure in line with NICE guidelines that follow-up appointments are made to review the progress of prisoners prescribed antidepressants.	Accepted	This will be reviewed at the next medicines management committee meeting to ensure that NICE guidance are being achieved and appropriate steps will be put in place to ensure that all follow up appointments are carried out, including the review of progress of prisoners prescribed anti-depressants	30/11/2013	
5	The Governor should ensure that case managers follow the guidance in PSI 64/2011, ensure multidisciplinary attendance at case reviews, and do not close an ACCT plan until the actions in the caremap have been achieved.	Accepted	To be reviewed with appropriate actions to ensure multi-disciplinary attendance at case reviews. To raise the awareness of managers and staff additional Safer Custody training is now being run which will include the ACCT document and requirements of the caremap. There will be a lockdown training event every two months to facilitate this.	Completed	

6	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	A Notice to Staff (NTS 168/2013) was issued on the 2nd October to remind staff to check the wellbeing of prisoners when unlocking. Staff were also reminded that they can request for an ambulance without waiting for Healthcare staff to attend. A Governor's Order (10/2013) was issued on the 14th August 2013 to instruct staff on what to do when unlocking prisoners, including obtaining a verbal response. The Head of Residence has put in additional management checks to ensure compliance when a cell door is unlocked, this management check is reported back at the Governors morning briefing	Completed	
7	The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate	Accepted	This requires consultation between the Governor and Care UK, taking into consideration the different guidance available to both groups (clinical and non-clinical). A meeting is taking place to provide staff with appropriate guidelines.	31/12/2013	