

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in December
2014 at HMP Risley**

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 Risley on 3 December 2014. He was 31 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care at the prison. Risley cooperated fully with the investigation.

In June 2014, the man was convicted of common assault and harassment and the court imposed a restraining order, preventing him from contacting his ex-partner. He was remanded to HMP Forest Bank. In 2009, the man had seriously self-harmed at Forest Bank, during a previous prison sentence, from which he had been released in 2012. He suffered from schizophrenia and had spent some time in hospital in the community. Shortly after the man arrived at Forest Bank, the safer custody team noted his previous self-harm, but officers on his wing spoke to him and accepted his assurances that he was fine. In July, he was given a 12 month sentence, with a release date of 23 December. He transferred to Risley in August. Although he was reluctant to engage, a mental health nurse reviewed the man periodically and had no significant concerns about him. On the afternoon of 3 December, the man was found hanged in his cell.

No one at Risley had identified the man as at risk of suicide. He was due to be released from prison in less than three weeks and had given no indication to staff, prisoners or his family that he was considering taking his own life. While the man always had some underlying risk factors for suicide, I am satisfied that staff at the prison could not have foreseen or prevented his death. A quicker response would have been unlikely to have affected the outcome for the man, but I am concerned that there was a delay in calling an ambulance after an emergency medical code was called. In other circumstances, such a delay could be crucial.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. On 24 June 2014, the man was convicted of common assault and harassment and was remanded to Forest Bank. The court made a restraining order preventing him from contacting his ex-partner, the victim of his offence. The man had been in prison before. In 2009, during a previous prison sentence, he had seriously self-harmed at Forest Bank, by cutting his arms and throat and staff supported him using suicide and self-harm prevention measures. He was released from this sentence in March 2012. The man suffered from schizophrenia, for which he took medication and had been admitted to hospital several times.
2. When he arrived at Forest Bank, the man had several factors that indicated that he was at increased risk of suicide and self-harm. He had been diagnosed with schizophrenia (which significantly increases the risk), he had previously harmed himself in prison and his offence was against a former partner. Reception staff did not identify these risk factors, but a member of the safer custody team noticed his previous self-harm and asked officers to check the man. He assured them there was no reason for concern.
3. On 15 July, the man was sentenced to 12 months in prison and transferred to Risley on 19 August. His release date was 23 December. At Risley, a nurse from the mental health team supported the man, although he was reluctant to have any active engagement. No one considered he would kill himself.
4. At 2.14pm on 3 December, another prisoner saw that the man had hanged himself in his cell. Staff responded quickly and called an emergency medical code, but the control room did not call an ambulance until five minutes later. Nurses performed cardiopulmonary resuscitation until paramedics arrived. At 3.06pm, the paramedics pronounced the man dead.
5. Although we would have expected reception staff at Forest Bank to have identified the man as at risk of suicide and self-harm when he first arrived at the prison, we are satisfied that afterwards, apart from his underlying risk factors, there was little to indicate that the man was at heightened risk. He did not give any indication to staff and prisoners at Risley, or his family, that he was considering suicide and we do not believe that prison staff could have predicted or prevented his actions. While it is unlikely to have affected the outcome for the man, the prison did not call an ambulance as soon as an emergency code was called, as should have happened. We make one recommendation.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at Risley, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
7. The investigator visited Risley on 11 December and obtained copies of the man's prison and healthcare records. NHS England appointed a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer interviewed 10 members of staff and one prisoner at Risley.
8. The investigator informed HM Coroner for Cheshire of the investigation. We have sent the coroner a copy of this report.
9. One of the Ombudsman's family liaison officers contacted the man's family to inform them of our investigation and to invite them to identify relevant issues they wanted the investigation to take into account. They said that the man's death had been a massive shock, as in his recent letters he had written about his future. They noted that the prison had told them that he had not been monitored as at risk of suicide, and had not been bullied, and asked for further details about his time in prison. His family asked us to clarify whether he had had any mental health problems or treatment at Risley, and when he had been due for release. The man's family received a copy of the draft report. They did not make any comments.

HMP RISLEY

10. HMP Risley is a category C resettlement prison, which can hold 1095 convicted adult men. Bridgewater NHS Trust provides healthcare services in the prison

HM Inspectorate of Prisons

11. At the most recent inspection of Risley, in July 2013, inspectors found that most prisoners felt safe. Reception arrangements were adequate. Inspectors noted that the prison had acted on lessons learned and recommendations from previous investigations into deaths at the prison. Support for prisoners at risk of suicide and self-harm was generally good, with some excellent multidisciplinary work. Inspectors found that a previous recommendation that there should be effective emergency response procedures, including sufficient first aid-trained staff on duty at all times, had not been achieved. Mental health services were judged as reasonable.

Independent Monitoring Board

12. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to March 2013, the IMB commented that incidents of serious self-harm were reduced by the prompt action and skill of officers. They reported that the quality of ACCT documents was good.

ACCT - Assessment Care in Custody and Teamwork

13. Assessment, Care in Custody and Teamwork, known as ACCT, is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. 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. Support for prisoners includes setting a number of significant interactions with them during the day, supplemented by checks on their well-being during the times they are locked in their cell.
14. Part of the ACCT process involves assessing immediate needs and drawing up a care-map to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the care-map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at HMP Risley

15. The man's death was the third self-inflicted death at Risley since 2012. There were no significant similarities between these two deaths and the man's death.

KEY EVENTS

16. The man had first served a prison sentence in 2007 and previously spent time at Forest Bank and Risley. The man had seriously self-harmed when he was at Forest Bank in 2009 by cutting his arms and throat and staff had monitored him under suicide and self-harm prevention measures. He was released from prison in March 2012. The man was diagnosed with schizophrenia, for which he took medication. He had been admitted to hospital several times in the community, for mental health problems.
17. On 24 June 2014, the man was convicted of common assault and harassment, and remanded to Forest Bank. The court imposed a restraining order preventing the man from contacting his ex-partner, the victim of his offences. He was remanded to Forest Bank. Despite his risk factors, including previous self-harm in prison, his diagnosis of schizophrenia and his relationship to the victim of a violent offence, reception staff did not identify him as at risk of suicide and self-harm. However, a member of the safer custody team noted that the man had previously harmed himself at Forest Bank and asked wing staff to speak to him. An officer spoke to the man and noted that he had explained the support available to him in prison. He did not consider that the man was at risk of suicide and self-harm. Another member of staff recorded that the man had received a full prison induction, including further information about the support available.
18. On 15 July, the man was sentenced to 12 months in prison and transferred to Risley on 19 August. His release date was 23 December 2014. When he arrived at Risley, reception staff did not assess him as at risk of suicide and self-harm and the man said that he did not have any immediate issues. An officer on the first night unit noted that the man was subject to a restraining order and had previously harmed himself in prison.
19. On 26 August, a Supervisory Officer (SO), his offender supervisor (responsible for implementing sentence plans) saw the man and gave him a letter with confirmation of his release date. The letter said that the man would be eligible for home detention curfew after 24 September, and that Shelter (a housing charity) would help him with accommodation issues.
20. The man did not work at the prison and spent most of the day in his cell, which was a single cell. Doctors had prescribed olanzapine, (antipsychotic medication) for schizophrenia while he was in the community and his prescription continued in prison. He agreed to meet someone from the mental health team, though he said he did not need any support.
21. On 8 September, a member of the mental health team, saw the man for a mental health assessment. The man said that he did not think that he needed mental health support in prison as he was coping well and had no problems. He said that he sometimes heard voices but was able to manage them. He said he had no thoughts of suicide or self-harm. The mental health nurse told the man that she thought that he needed mental health support while in prison. The man reluctantly agreed to have reviews every six weeks and said that he would contact the nurse if he felt he needed additional support or felt ill.

22. On 11 September, the SO told the man that he was not suitable for release on home detention curfew, because he had previously committed an offence while on a suspended sentence.
23. On 8 October, the nurse saw the man for a mental health review. The man said that he was coping well and had no issues with his medication. He said his sleep was disturbed, although he thought that he was getting enough. He said he did not intend to get a job at the prison. The nurse recorded that the man would be released in December and the man agreed to a further review in six weeks.
24. On 14 October, the man pressed his cell bell. An officer answered the bell and found that the man had covered his observation panel and barricaded his cell. The man told staff that he would explain to the Governor why he had done this, but said that he did not feel right on the wing. Officers charged him with a disciplinary offence under Prison Rule 51, paragraph 3 (denying an officer access to any part of the prison).
25. On 29 October, an operational manager, conducted the adjudication (disciplinary hearing). The man said that he had barricaded his cell, as he had felt unsafe because he had a bad name from the last time he had been at Risley. The Head of Operations asked the man to explain why he felt unsafe and name any specific prisoners he was afraid of. The man repeated that he had a bad name the previous time he was at Risley but refused to give any further details or name anyone.
26. At interview, The Head of Operations did not recall the hearing, and relied on the written record. He found the man guilty and imposed a punishment of stoppage of 50% of the man's earnings for 14 days. He also lost canteen (use of the prison shop), use of private cash, use of a television and association for 14 days. The Head of Operations said that he had asked if the man was medically fit to proceed, but there is nothing on the record to indicate that he was aware that the man suffered from schizophrenia or considered whether his actions might have been related to his mental illness.
27. On 10 November, a member of staff from the careers service, saw the man to discuss his plans for after release. The member of staff told the investigator that he did not remember the man specifically, but from his notes was aware that the man was due to be released on 23 December. The man said that he had lost his tenancy when he was sent to prison and was not sure where he would live after his release. He said that he would claim benefits when he was released as he did not have a job. The member of staff referred the man to Shelter and Jobcentre Plus so that they could help him with accommodation and advise about benefits.
28. On 27 November, the nurse saw the man for a mental health review. The man said that he felt well and was looking forward to his release on 23 December. He said he did not know whether he would have licence conditions and did not know who his offender supervisor or offender manager (his probation officer in the community) were. (the SO was his offender supervisor.) The nurse recorded that she would refer him to the community mental health services. The nurse noted that she would not have another review with the man before his release, but would keep him on her caseload, in case he asked to see her.

29. On 29 November, the man asked to move wings, as he said he found B Wing too noisy and wanted some peace for the last weeks of his sentence. A Supervising Officer (SO) was dealing with a prisoner who wanted to move from C Wing and when she spoke to officers on B Wing, they suggested a swap with the man. She arranged the move and so the man went to C Wing the same day.
30. A prisoner at Risley, told the investigator that he had been friends with the man for a number of years and knew his family. The prisoner had been on B Wing with The man. The prisoner said he used to help the man with reading and writing and had helped the man make an application to move to C Wing. However, he had tried to talk him out of it, as he did not think the man knew anyone on C Wing, whereas he knew the prisoner and other prisoners from his home area on B Wing. The prisoner said that, at first, the man said he had been bullied on B Wing, but that turned out not to be true. (There is no record of the man reporting bullying and it is possible this refers to the incident when he barricaded his cell.) He thought that the man just wanted a move as a way of breaking up his sentence. The only thing he was aware of that might have been troubling the man, was that he was scared of his ex-partner and her new boyfriend who was 'after' him. He said he had seen the man just before he moved to C Wing and he seemed happy to be moving. The prisoner had been very surprised when he learnt of the man's death, particularly as he had been looking forward to his release and spending time with his mother and brother over Christmas.
31. During his time at Risley, the man frequently phoned his mother. The investigator listened to recordings of the last four calls the man made. The last call he made was on Sunday 30 November, the day after he moved to C Wing. In each call, the man said that he was looking forward to being released on 23 December, and being with his mother. In the last call, the man said that he was going to get on with his life and that he would claim benefits once he was released. He said he would write to his mother during the week and call her again in four days.
32. At about 2.10pm on Wednesday 3 December, a prisoner wing cleaner, looked through the observation panel in the man's cell door and saw that he was hanging. (The wing cleaner did not want to be interviewed for this investigation so we have no further detail from him about this or why he had looked into the cell.) The wing cleaner alerted staff and two officers and a nurse responded. The officer told us that a group of prisoners were outside the man's cell (which was two landings above him), and he told them to press the general alarm. The officer went up to the cell, looked through the observation panel and saw the man apparently sitting in a strange position directly below the electric sockets, which were protruded from the wall and were high enough for the man to suspend himself from.
33. The officer immediately went into the cell and found that the man had hanged himself from a ligature made of torn bedding, attached to the electric socket. With the wing cleaner's help, the officer cut the ligature and placed the man on the floor. The nurse checked for vital signs and started cardiopulmonary resuscitation, assisted by the officer. The officer radioed a code blue emergency and then took the wing cleaner away from the cell. Two other

nurses arrived, within a minute of the emergency call. They attached an automated external defibrillator (which monitors the heart rhythm and administers electrical shocks to restore a normal rhythm when possible). The defibrillator did not detect a shockable rhythm.

34. The control room log shows that the officer radioed the code blue at 2.15pm. Control room staff did not make the 999 call until 2.20pm. The nurse told us that she asked them to do this, as she had not been sure that anyone had called an ambulance. Paramedics arrived at 2.33pm and took over the man's care. At 3.06pm, they pronounced the man dead. The man did not leave a note.
35. An operational support grade (OSG), told the investigator that she was on duty in the control room at the time of the code blue call. She said that the standard practice was for control room staff to wait to be told if an ambulance was required. The OSG knew that there was an instruction that they should call an ambulance immediately when a medical emergency code was used and was aware of the codes. However, she said that control room staff had not called ambulances immediately "for a long time".

Contact with the man's family

36. That evening, at 7.50pm, the Governor, and the Reverend, a prison chaplain and family liaison officer, visited the man's mother to break the news of his death and to offer condolences and support. There was a delay, as the man had given a different address for his mother. Risley maintained contact with the man's family for ongoing support and contributed towards funeral expenses, in line with national guidance.

Support for prisoners and staff

37. A manager debriefed the staff involved in the emergency response, discussed what had happened and offered the services of the prison's care team. Officers and members of the chaplaincy team supported prisoners affected by the man's death. Staff reviewed prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by the man's death.

ISSUES

Assessment of risk

38. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, previous self-harm, being charged with a violent offence, particularly against a family member, and a history of mental health problems. New prisoners must be interviewed in reception so that staff can assess their risk of suicide or self-harm. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and act appropriately to address any concerns, including beginning Prison Service suicide and self-harm prevention procedures, known as ACCT, if necessary.
39. We have considered whether staff should have monitored the man under the ACCT process during his current sentence. People with mental health problems are at increased risk of suicide and self-harm. The man suffered from schizophrenia, which research has shown increases the risk of suicide by up to 12 times. In 2014, we published research into risk factors in self-inflicted deaths in prisons and three quarters (76%) of our sample had mental health problems. However, a history of mental health problems is not unusual in the prison population. While it is important to be aware of the risk, it would not be reasonable to support them all using ACCT procedures, but other risk factors need to be taken into account.
40. When the man arrived at Forest Bank, he had been convicted of harassment and common assault against an ex-partner. The court made a restraining order to protect his victim. Offences of violence are another factor that increases the risk of suicide and self-harm. The man had also previously self-harmed in prison. It is not clear from the record whether staff took these risk factors into account when the man arrived at Forest Bank. We would have expected reception staff to have identified the man as at risk of suicide and self-harm. The assessment of risk on arrival is a matter about which we have made a number of recommendations to Forest Bank. We do not make one here as we are satisfied that after his arrival, there was little to indicate that the man was at heightened risk (although his underlying risk factors would always remain). Shortly after he arrived, a member of the safer custody team at Forest Bank identified that he had previously harmed himself and asked wing staff to speak to him to see whether he needed additional support.
41. Although the man did not consider he needed additional support from the mental health team at Risley, he agreed to meet the nurse from the mental health team every six weeks. It seemed that he controlled his schizophrenia well by taking his medication as prescribed. The nurse assessed the man's mental state and was not concerned that he was at risk of self-harm or suicide. The nurse reviewed him less than a week before he died. No one else at Risley identified any concerns about the man.
42. The man's family asked whether he had been bullied at the prison and whether this was a factor which had increased his risk of suicide. The investigator found no security intelligence that indicated that the man was the victim of bullying. After he barricaded his cell on 14 October, the man suggested that he did not feel right on the wing, but he declined to give any substantive information.

Although the man said at the hearing that he did not feel safe at Risley, because he had a bad name from when he was previously there, he did not explain further. The prisoner, a friend of the man's who lived on B Wing at the same time, said he did not think that the man was being bullied. When he asked for a wing move, he did not suggest that this because of bullying from other prisoners, only that he wanted to move to a quieter wing. We found no evidence linking the man with bullying and nothing to suggest that bullying was a factor in his death.

43. We are satisfied that the man gave no indication to staff, or his family, that he was contemplating taking his own life. While his illness meant he was always at increased risk of suicide and self-harm, there was no indication that he was at particular risk at the time, which would have indicated that staff should have opened an ACCT while he was at Risley.

Clinical Care

44. The clinical reviewer, noted that the man saw a psychiatric nurse on three times between August 2014 and December 2014 at Risley. The nurse completed a care plan and a risk assessment. Although the man did not see a psychiatrist, a GP reviewed his medication. When he spoke to healthcare staff, the man did not give any indication that he intended to take his own life. The clinical reviewer was satisfied that the man's clinical care at Risley was equivalent to that of a patient in the community.

Emergency Response

45. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. Risley has a local protocol that meets the requirements of the national instructions.
46. The officer correctly called a code blue emergency at 2.15pm, when he found the man hanged in his cell. However, the control room did not request an emergency ambulance until 2.20pm after a nurse asked them to. There is no evidence to suggest that this delay affected the outcome for the man, but in other cases, such a delay could be crucial. Control room staff told us that, after an emergency medical code, they wait for officers or healthcare staff to tell them to call an ambulance before doing so. This is contrary to the national and local instructions. Managers at Risley need to ensure that all staff follow these instructions. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance as soon as a medical emergency code is called.

RECOMMENDATION

The Governor should ensure that control room staff call an ambulance as soon as a medical emergency code is called.

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 control room staff call an ambulance as soon as a medical emergency code is called	Accepted	<p>The Governor will send a personal letter to all staff who regularly work in the control room, reminding them of their responsibilities with regards to ensuring that there is no delay in calling an ambulance after a medical emergency code is called.</p> <p>The Safer Custody team will republish local guidance with regards to medical emergency codes twice a year. They will also reissue reference cards for all staff and republish the emergency codes in all areas.</p>	31 July 2015 Head of Safer Custody	