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 May 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 in May 2014. He was 40 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Risley was undertaken. The prison cooperated fully with the investigation.

In June 2013, the man was sentenced to six years and three months in prison. After several months in closed conditions, he transferred to HMP Kirkham, an open prison, on 8 May 2014. Before his imprisonment, he had been diagnosed with bipolar disorder. After he arrived at Kirkham, he said that he was finding it difficult to cope and said he might harm himself or abscond. Staff began Prison Service suicide and self-harm support procedures and considered that he would receive more supervision and help at a closed prison. On Friday 16 May, he transferred to HMP Risley.

When the man arrived at Risley, a supervising officer in reception closed the support procedures which had just begun that morning. Nurses were concerned about his mental state and began them again almost immediately afterwards. A mental health nurse ensured that he had his correct medication for the weekend and asked staff to check him hourly. On the day he died, a prison chaplain went to see him and found him very distressed. The chaplain tried to bring forward a review of his risk to ensure he received appropriate support. The managers responsible decided, without seeing him, that he did not need a review. The required hourly observations did not take place that day. He was last seen alive at 7pm. At officer checked him at around 8.40pm and found he had hanged himself with his belt attached to the bed. Staff tried to resuscitate him but, sadly, he had died.

The investigation found a number of deficiencies in the operation of suicide and self-harm prevention procedures at Risley, which the prison will need to address. A number of staff seemed to underestimate the man's risk to himself, when they knew little about him, and without the input of trained mental health staff. I am particularly concerned that staff failed to act on the warnings of the prison chaplain, who was very worried about his state of mind and that on the day he died officers did not check him hourly, as they were required to do.

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 **May 2015**

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SUMMARY

1. In June 2013, the man was sentenced to prison for six years three months. On 8 May 2014, he transferred to HMP Kirkham, an open prison.

2. On 9 May, the man told a nurse that he was feeling low. On 16 May, he was still feeling low and said that he might harm himself or abscond. The nurse began Prison Service suicide and self-harm prevention procedures (known as ACCT - Assessment, Care and Teamwork in Custody). After seeing a mental health nurse, he agreed to move to the segregation unit. Staffing levels in open prisons are low and staff decided that he should go to a closed prison which would be able to give him more supervision and support. He moved to HMP Risley that afternoon.

3. When the man arrived at Risley, a supervising officer (SO) held an ACCT case review and decided to close the ACCT. The SO believed that the ACCT had been opened only as a precaution while he transferred. It is not clear how she reached that view. She referred him to see a mental health nurse urgently, as he was worried about his medication.

4. A reception nurse noted that the man seemed very low and difficult to engage. The nurse was concerned that the SO had closed the ACCT and asked a mental health nurse to review him. The mental health nurse reopened the ACCT and arranged for him to have some sleeping tablets for the weekend, in addition to his regular medication for bipolar disorder. She noted that staff should check him every hour and made an appointment for him to see a doctor on Monday 19 May.

5. The man did not attend his appointment with the doctor. No reasons were recorded. A chaplain visited him and found him very low in mood. He asked to go to the segregation unit and said he had thoughts of harming himself. The chaplain discussed his concerns about him with wing staff and asked that his next ACCT review be brought forward.

6. The man's ACCT case manager, a supervising officer, reviewed his ACCT document and decided that a case review was not urgent so did not hold one. She did not speak to him or the chaplain who had raised the concerns about him before deciding this. The chaplain later raised his concerns with the orderly officer but she did not review him either.

7. An officer noted that the man was lying awake on his bed at 7pm. Although staff were expected to check him at least once an hour, an officer did not check him again until sometime after 8.40pm. He was unresponsive and had tied a belt around his neck and attached it to the bed. Prison staff were unable to resuscitate him and paramedics arrived and pronounced him dead.

8. The investigation found that opportunities to support the man were missed. We are concerned that ACCT procedures were not followed correctly and two supervising officers involved with him missed opportunities to help him. We

are also concerned that the officer who found him unresponsive did not use the correct emergency code. This report contains nine recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices informing staff and prisoners at HMP Risley of the investigation and inviting anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of the man's prison records, including his prison medical record. She interviewed 17 members of staff.

11. NHS England commissioned a clinical reviewer to review the man's clinical care in prison. He was present for the interviews with healthcare staff.

12. We informed HM Coroner for Warrington of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation. She wanted the investigation to consider the following :

- Why was her brother transferred from a category D to a category C prison and why was he sent to Risley?
- Why did it take so long to get through to someone at Risley who took her concerns about his welfare seriously?
- Why was his request to go to the segregation unit not seen as a cry for help?
- Why was his ACCT document closed and re-opened?
- Was he distressed and banging on his cell door?
- Did he have a problem with any other prisoners?
- Why was his last ACCT observation 40 minutes overdue?

14. The man's sister received a copy of the draft report. The solicitor representing her wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP RISLEY

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

HM Inspectorate of Prisons

16. The most recent inspection of HMP Risley was in July 2013. Inspectors found that most prisoners felt safe. Reception arrangements were adequate but could be improved. Inspectors found that the prison had acted on lessons learned and recommendations following previous investigations into deaths at the prison. They found support for those at risk of suicide and self-harm was generally good, with some excellent multidisciplinary work. Inspectors noted 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.

Independent Monitoring Board

17. 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.

Previous deaths at HMP Risley

18. The man's death was the second self-inflicted death at Risley since 2012. There are some similarities between the two deaths. In the previous investigation report into the death in 2012, we made recommendations to Risley about the assessment risk of suicide and self-harm, ACCT procedures and delays in emergency response. We make similar recommendations in this report.

Assessment, Care in Custody and Teamwork - ACCT

19. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as being at risk, the purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a 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 of the actions on the caremap have been completed.

KEY EVENTS

20. The man was remanded to HMP Durham on 26 September 2012, charged with drugs offences. On 17 June 2013, he was sentenced to six years and three months in prison. In July 2013, he transferred to HMP Haverigg. In March 2014, he successfully applied to have his security status reduced to category D. This meant that he could go to an open prison. On 8 May, he transferred to HMP Kirkham.

21. At a reception health assessment at Kirkham, the man said that he had bipolar disorder, for which he took olanzapine, an antipsychotic medication. He said that he was happy to be at the prison but felt a bit nervous.

22. On 9 May, the man had another health assessment with a nurse. He said that he felt unsettled and low in mood. The nurse referred him to the mental health nurse.

23. On 12 May, the man told a prison chaplain that he was a loner, had bipolar disorder and was finding it hard to settle in. He said that he would prefer to be at HMP Kennet which was closer to his family.

24. On 14 May, the mental health nurse reviewed the man's mental health referral and arranged an appointment at the prison's mental health assessment clinic on 20 May.

Friday 16 May

25. On the morning of 16 May, the man went to the healthcare unit and said that his medication would run out that day. He told a nurse that he felt very low in mood and unpredictable. He said that he had no current thoughts of self-harm or absconding from the prison, but that this might change as he could only think half an hour ahead. She opened an ACCT document and told the mental health nurse about how he was feeling.

26. The mental health nurse saw the man shortly afterwards. He repeated that he had no current thoughts of harming himself or others but that this could change. He said that he had not been sleeping or eating well. She asked him if he was thinking of absconding and he could not assure her that he would not. She discussed the situation with the prison's duty manager and they decided to move him to the segregation unit in case he decided to abscond. He said that he did not mind being held in the segregation unit and asked if it was quiet. He asked to be transferred to HMP Kennet.

27. Later that morning, a risk management meeting assessed whether the man should stay at Kirkham. The duty governor, mental health nurse and an offender supervisor attended and concluded that he would benefit from closer supervision and the support of a closed prison environment. They discussed his request to go to Kennet but decided that, as a partially open prison, it would not provide the additional supervision and support that he needed. They decided that HMP Risley would be a suitable prison as it would be

nearer to his family in Liverpool, although not as close as Kennet. Staff held an ACCT review with him at 11.30am and agreed that his anxiety and mental health problems should be addressed by a move to another prison.

28. An officer wrote in the man's ACCT document that he appeared a lot calmer at lunchtime. He stayed in the segregation unit until officers took him to Risley at 1.20pm. The escorting officer wrote in his ACCT document that he said he was unhappy about being transferred to Risley but had to accept the decision.

29. The man arrived at Risley at around 2.30pm. At 3.00pm, a Supervising Officer (SO) and an officer held an ACCT review with the man in reception. The SO told the investigator that she talked to him for 40 minutes and he was "fine" and "quite chirpy". She said he was happy to have been given his socks and underwear from his property. His only concern was whether he would be able to get his antipsychotic medication. She checked with a nurse, who said that he would receive his medication that day. She made an urgent referral for him to see the mental health team and followed this up with a telephone call. She said that she made the referral because he was bipolar and was worried about his medication. He told her that he had no thoughts of self-harm.

30. At the end of the review, the SO decided to close the ACCT. She told the investigator that she did not know why the man had returned to closed conditions or moved from Kirkham. She said that it was not recorded in the ACCT. (However. there was an entry in the ACCT made by a custodial manager, who had held a case review with him when he was in the segregation unit at Kirkham. It said that he was clearly distressed and not coping. He said that the man was to be moved to an establishment that could provide more care than Kirkham.) The SO said that the man was settled and happy to be at Risley. She thought that the ACCT had been opened as a precaution while he moved from one prison to another, not because he was perceived to be at risk of suicide or self-harm. She said that she was content to close the ACCT because nothing about the man's demeanour indicated that he was thinking of harming himself. The caremap actions to deal with his anxiety and mental health problems had not been completed.

31. At 3.50pm, a nurse saw the man as part of the reception process. She told the investigator that he presented as "very flat, down and depressed". She said that the ACCT document had been closed when she saw him, but that she was concerned about him and asked a mental health nurse to see him. She told the investigator that the man talked about harming others and said that he had been banging his head earlier that day in the segregation unit at Kirkham because he had been angry. The nurse said that the conversation was difficult because he gave only one word answers. She phoned the doctor and asked him to prescribe the man's olanzapine. She made an appointment for him to see a doctor first thing on Monday 19 May.

32. A mental health nurse went to see the man immediately she received the nurse's call. She told the investigator that he was very flat and monotone.

She asked him about his history and was concerned about his wellbeing and his risk to others. She said that he told her he had had thoughts of ending his life but would never act on them because of the devastation he knew it would cause his family.

33. The mental health nurse re-opened the ACCT plan at 4.30pm, and noted that staff should check him once an hour. She wrote that the man was agitated and had banged his head on a wall earlier. He told her that he had done this to stop himself from hitting out at others. In addition to his antipsychotic medication, the mental health nurse asked the doctor to prescribe some zopiclone (sleeping tablets) to help him over the weekend. The doctor prescribed his medication but did not see him that day.

34. The mental health nurse told the investigator that there are no mental health nurses or doctors in the prison at weekends. However, she thought that the man would receive sufficient support through the ACCT process over the weekend. She was satisfied that he had been prescribed his medication and that he would see the doctor on Monday morning.

35. The man was assessed as unsuitable to share a cell with another prisoner because of his risk of violence. He was given a single cell on D wing, the induction wing for new prisoners.

Saturday 17 and Sunday 18 May

36. At 10.30am on Saturday 17 May, an SO chaired an ACCT review with another SO, and a chaplain was also present. The SO told the investigator that the man's ACCT document recorded why he had been returned to closed conditions. The SO said that the man appeared withdrawn and sullen and that it was quite a difficult review. The SO said that he knew the man was bipolar and it was clear that he needed mental health support. He said that the man talked about wanting to transfer to Kennet and the SO said that could be discussed at the next ACCT review. The SO thought it appropriate to keep him on hourly observations. The review assessed his level of risk of suicide and self-harm as raised. The SO recorded that someone from the mental health team and the man's offender supervisor should attend the next review. The review team did not update his caremap.

37. In the afternoon, the chaplain went to see the man as a routine chaplaincy visit for new arrivals. The man asked to see a Roman Catholic chaplain and the chaplain left a message in the chaplaincy asking them to visit him.

38. Entries into the man's ACCT document over the weekend noted that he was quiet and spent a lot of time sleeping in his cell, during the day and night.

39. The man had an appointment to see the doctor in the morning, but he did not attend. The reason for his non-attendance was not followed up.

40. A prison chaplain visited the man at around 11.30am and found him in a very low mood. The man told him that he wanted to go to the segregation unit and

had thoughts of harming himself. The chaplain told the investigator that the man was very clear that he did not want to be at Risley and he had genuine concerns about the man's well being. He told him that he would try and get his next ACCT review brought forward for later that day.

41. The chaplain told wing staff about his conversation with the man and that he had asked to go to the segregation unit. He wrote his concerns in the man's ACCT document, prison file and in the wing observation book. He checked when his next ACCT review was due, which was at 2.30pm the next day, 20 May and phoned the safer custody department and explained his concerns about him. He asked that his ACCT review should be brought forward. He told the investigator that a member of the safer custody department said she would pass his concerns on to her colleague who scheduled ACCT case reviews.

42. At around 3.00pm, a member of safer custody contacted the chaplain and told him that he had been trying to arrange an ACCT review for the man that day, but his offender supervisor, who needed to chair the review, said that she was too busy and had decided to leave the review to the scheduled date, 20 May. The chaplain told the investigator that he and the safer custody member agreed that the man needed an urgent review and they were both concerned by the offender supervisor's response. The safer custody member told the chaplain that he was doing all he could to resolve the situation.

43. The offender supervisor told the investigator that the safer custody member had called her at 2.30pm and asked her to hold an ACCT case review for the man, as there were concerns for his safety. She said it was not until then that she had found out that she had been allocated as his offender supervisor. She told the investigator that she checked his prison record and telephoned the wing and spoke to an officer on D wing. She said that the officer she spoke to said that he was okay. She said that she was unable to get hold of the chaplain to discuss his concerns and decided to go to the man's wing and check his ACCT document and speak to staff. (She told the investigator that she thought it was a particular officer that she spoke to on D wing. This officer had no recollection of this conversation and said that he was not working on D wing that afternoon.)

44. The offender supervisor told the investigator that when she arrived on the wing there were no staff available to speak to. She said that she checked only the recent entries in the man's ACCT document, including the entry made by which said: 'Met with the man - was very low in mood. Mentioned thoughts of self-harm and wants to go to the Seg". Although she was on D wing, she did not to go and see him. The offender supervisor told the investigator that she did not know why she had not gone to see the man. She did not write anything in his ACCT document. She told the investigator that, although he was new to the prison, had been returned to closed conditions and was being monitored under ACCT procedures, she did not think he was at a heightened risk of suicide or self-harm. She told the investigator that she decided that there was no need to hold an ACCT review that day because there was nothing to indicate that he was at imminent risk of killing himself or

harming himself. She decided that the ACCT review could be left until the next day. She said that she discussed her decision not to complete a case review with a colleague, who agreed. She left the prison at 5.00pm.

45. The chaplain told the investigator that, at around 4.00pm, he received a call in his office from the man's sister. She was very distressed and said that she had been trying to find out where her brother was since Sunday after she had tried to visit him at Kirkham. The man's sister said that she had been ringing Risley since early in the morning to try and raise concerns about his welfare but had been "passed from pillar to post". She was worried that he had not contacted his family to tell them he had moved prison. He told her that her brother was at Risley and that he had seen him that morning. He told her that he would go back and see him and ask him to call her.

46. The chaplain went back to D wing at around 4.45pm and asked to see the man. He said that an officer told him that the man was very upset and wanted to go to the segregation unit. (The chaplain told the investigator that, while he knew the officer by sight, he did not know his name.) He told the investigator that this officer and another officer on the wing then accompanied him to the man's cell. He said that the two officers went with him because the man was agitated and they were concerned for the chaplain's safety. (The chaplain recorded this in an entry in the man's prison file and in the wing observation book shortly afterwards.) An officer told the investigator that the chaplain had asked him to accompany him to the man's cell and that he was the only officer with him. There were no entries in the ACCT which said that the man had been agitated or was likely to pose a risk to staff.

47. The chaplain told the investigator that he told the man that his sister had called and encouraged him to contact her. He said that the man kept repeating that he wanted to go to the segregation unit. He told the chaplain that he had not had an ACCT review. The chaplain said he spent about five minutes with him and told him he was going to find out what was happening about his review. He said that he told the officers that the man really needed an ACCT review and that it was unacceptable that one had not yet been held.

48. An officer told the investigator that, after he left the cell, wing staff did not discuss the man's request to go to the segregation unit. The chaplain recorded details of his conversation with him in the D wing observation book, but not in the ACCT document.

49. The chaplain returned to his office and, at 5.15pm, contacted the safer custody department to find out why the man had not had an ACCT review. He spoke to an administrator for the safer custody team. She told the investigator that, after speaking to the chaplain, she tried to contact D wing and then the offender supervisor to find out what was going on. She could not get through to either. She said that she discussed the situation with the Head of Safer Custody at Risley. She said that he told her to contact the orderly officer in charge of the prison that evening. She said that she tried to contact the orderly officer but got no response. As it was now past 5.00pm and she had personal commitments, she telephoned the chaplaincy office. The

chaplain was not in the office so she told another chaplain that the other chaplain should try to contact the duty manager himself.

50. The Head of Safer Custody told the investigator that he knew the man had been trying to arrange an ACCT review for the man that day. He said that he had advised the administrator to contact the orderly officer, whose responsibility it was to arrange the review. He told the investigator that he often chaired ACCT reviews and if he knew one needed to be carried out, he could arrange for it to happen or could go and see the prisoner himself to assess the situation. He did not arrange one for the man. He had no further involvement with his ACCT process and never met him.

51. The chaplain received the administrator's message that he should contact the orderly officer, and telephoned her. He told the investigator that he had explained the day's events and told the administrator that the man needed to be seen. The chaplain said that she asked him if the man had harmed himself and he told her that he had not done, so far. He said that the administrator told him that the man would not be moved to the segregation unit and that he would have an ACCT case review the next day.

52. The orderly officer told the investigator that the first she knew of any concerns about the man was when she received the call from the chaplain. She said that she had explained to him that the segregation unit was not an appropriate place for someone on an ACCT. She told the investigator that he did not ask her to hold an ACCT review and that no one else had asked her to do so. She said that she followed up her conversation with him by speaking to staff on D wing and they told her that the man was agitated but that they were handling it. The officers told her that he had not collected his medication from the healthcare centre that evening.

53. The orderly officer said that she had spoken to wing staff about the man. She was not entirely sure who they were, but they were three officers. She said that she did not receive any information that made her think that she needed to review the man's level of ACCT observations. She said that when she later saw two nurses on another wing, she asked them to visit him that evening to give him his medication and that the nurses agreed to try and see him when they had finished their other duties. There is no record that a nurse saw him that evening.

54. An officer told the investigator that she did not know that the man had asked to go to the segregation unit. She knew that the chaplain had been trying to arrange an ACCT review, but she had not been involved in the arrangements. Another officer told the investigator that he had been escorting prisoners on the afternoon of 19 May and had no knowledge of him. Another officer said in a statement that she had started her shift on his wing at 6.25pm.

55. The orderly officer said that she went to D wing at 6.30pm to speak to another prisoner on an ACCT who was upset and asked officers about the man. The officers told her that he had calmed down and everything seemed okay.

56. There are only two entries in the man's ACCT document for that afternoon; one at 2.55pm and the next one at 6pm. Both entries record that the officers had no concerns about the man. There is no reference to him being agitated or wanting to go to the segregation unit or to the conversations about the need for an ACCT review.

57. Officer A noted in the man's ACCT document, at 7.00pm, that he was lying awake on his bed. Officer B told the investigator that, in fact, it was she who had checked him at 7.00pm while she was carrying out the roll check (when all prisoners are checked and counted). Because she was busy with other duties, she had asked Officer A to write the observation in the man's ACCT document.

58. Officer C arrived at the prison to begin a night shift at 7.15pm and the night orderly first asked him to take a prisoner who had arrived at the prison that evening to the healthcare unit. Officer C arrived on D wing at 7.25pm and three officers handed over to him. They told him that seven prisoners were being monitored under ACCT procedures, and how often they needed to be checked, and that a member of staff was constantly supervising one of the prisoners. He told the investigator that the officers did not say that there were any other specific concerns about the man.

59. When the newly arrived prisoner was brought to D wing, Officer C took him to his cell and by 7.40pm, was ready to begin other routine tasks. He told the investigator that he responded to a cell bell and then went back to the staff office at 7.50pm. When he got to the office, it was locked and all the other officers had gone. He was now the only officer on general duty on D wing. At 8.00pm, he decided to check the prisoners being monitored under ACCT procedures who had to be checked twice an hour. An officer and the night orderly officer visited D wing shortly after that. When they had left he again checked the prisoners needing two ACCT checks an hour. He said he began to check the prisoners needing one check an hour at about 8.36pm and he would have arrived at the man's cell at about 8.40pm. (Radio timings suggest that this was later.)

60. Officer C told the investigator that when he looked into the man's cell, he saw him lying on the floor, as if he was looking underneath his bed. He tried to get a response from him by shouting and kicking his door. He told the investigator that he then noticed a belt coming from the end of the bed frame towards the man's neck. He could not see that the belt was tied around his neck, but he was concerned and radioed for the night orderly officer to come to D wing. The record of radio calls indicates that this call was made at 8.49pm. Officer C said that he did not radio a code blue emergency call (which indicates a life-threatening situation such as when a prisoner is unconscious or has respiratory problems) because he did not yet know the situation.

61. A nurse heard the officer's call and asked for further information about the situation. The officer said that he replied that it was a "ligature". The investigator read the transcript of the radio calls made at the time, but the

officer's response to the nurse could not be heard. He asked for permission to go into the cell, but the night orderly officer told him to wait till help arrived. The orderly officer told the investigator that he needed more information before he could allow the officer to go into the cell. He said that he had not mentioned a ligature.

62. Shortly after Officer C's radio call for assistance, Officer D arrived on the landing and they both went into the cell. Officer C immediately radioed a code blue emergency at 8.52pm and asked for an emergency ambulance.

63. Officer D used his anti-ligature knife to cut the belt from around the man's neck. Both officers told the investigator that it looked as though he had died.

64. Officer C told the investigator that he listened to see if the man was breathing but there was no sign of life, He then started chest compressions. He said he gave 15 compressions and then paused to see if there was any change. After two further rounds of compressions, Officer D took over. Both officers told the investigator that they had had first aid training when they had first started as prison officers, some years previously, but had not received any follow up training.

65. The night orderly officer and a nurse arrived and the nurse asked Officer D to continue with chest compressions until he had applied the defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). The defibrillator did not detect any cardiac output and the nurse and the officer continued cardiopulmonary resuscitation until paramedics arrived at 9.05pm. The paramedics continued emergency treatment, but pronounced the man dead at 9.31pm.

Liaison with the man's family

66. One of the prison's family liaison officers came to the prison and she and the Governor went to break the news to the man's family that evening. He had named his sister as his next of kin and they went to her home and told her and other members of the family that he had died. In line with national guidance, the prison contributed to the funeral costs.

Support for staff and prisoners

67. After the Governor returned from visiting the man's family, he debriefed the staff involved in the emergency response, including the healthcare staff, to ensure they had the opportunity to discuss any issues arising, and to offer the support of the staff care team. Staff reviewed prisoners being monitored under ACCT procedures in case they had been affected by the news of the death and to ensure that they were given extra support if they needed it.

Post-mortem

68. The post-mortem examination concluded that the cause of the man's death was hanging.

ISSUES

Clinical Care

69. The clinical reviewer concluded that there were aspects of the man's clinical care that should have been better. A consultant psychiatrist had confirmed his diagnosis of bipolar disorder in May 2013. After the diagnosis, a psychiatrist should have reviewed him three months later and then at six monthly intervals. There is no evidence that the man was under the care of a psychiatrist at all during the year before his death. The clinical reviewer noted that he had had a previous admission to an acute mental health unit and had been seen by a consultant psychiatrist in prison. In these circumstances, he should have been subject to ongoing consultant care until a consultant formally discharged him.

70. After he was sentenced, the man moved from HMP Durham to HMP Haverigg in July 2013 and remained there until his move to Kirkham in May 2014. Healthcare staff at Haverigg were therefore principally responsible for ensuring his ongoing support and care. We make the following recommendation to HMP Haverigg:

The Head of Healthcare at HMP Haverigg should ensure that prisoners diagnosed with serious mental illnesses have well coordinated and effective care plans to facilitate appropriate continuity of care including psychiatric input when necessary.

71. The clinical reviewer noted that when the man first arrived at Risley, on Friday 16 May, two nurses identified that he was at risk of suicide or self-harm and made arrangements to keep him safe over the weekend, until he could be seen by a doctor. He noted that a nurse correctly identified his risk and opened an ACCT, after the reception supervising officer had just closed it. He considered that both nurses acted commendably in supporting him at the time.

72. However, the clinical reviewer was concerned that there was no dedicated mental health support available at weekends, other than a generic on-call community service. The man arrived on a Friday. This meant that at his ACCT review the next day, there was no mental health staff present. The supervising officer chairing the review noted that he needed mental health support. It is not possible to know whether additional mental health services over the weekend would have affected the outcome for him, but the lack of a service at weekends, particularly for prisoners who arrive on Fridays, is a problem. Kirkham had specifically transferred him to Risley because it would offer additional supervision and mental health support. We make the following recommendation:

The Head of Healthcare should ensure that there is sufficient dedicated mental health capacity at weekends and bank holidays to support prisoners assessed as at risk of suicide and self-harm because of mental health problems.

73. The man did not attend a doctor's appointment made for him for the morning of 19 May. There is nothing recorded in his medical record or in his ACCT document to explain why he did not attend. It is possible that his mental health deteriorated over the weekend and the clinical reviewer was concerned that no one actively followed up the missed appointment to ensure that the he was not disengaging as a result of a mental illness. We agree that this should have been done. Nor is there any evidence that nurses went to see him after he did not collect his medication on the evening of 19 May. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff actively follow up prisoners with mental health problems, identified as at risk of suicide or self-harm, when they do not attend planned healthcare appointments or collect their prescribed medication.

Assessing the man's risk of suicide and self-harm

74. The man began to show signs that he was not settling at Kirkham shortly after he arrived there. On Friday 16 May, he appeared to be in crisis and said he might harm himself or abscond. A nurse opened an ACCT plan and a mental health nurse assessed him promptly. After a risk management meeting, managers decided he should transfer to Risley which would be able to offer additional supervision and support to that available at Kirkham or Kennet, which was also considered. The mental health nurses contacted the mental health team at Risley to brief them about him.

75. When the man arrived at Risley, an SO held an ACCT review, without any member of healthcare staff present, despite his identified mental health problems. She decided to close the ACCT, but at the same time made an urgent referral for him to see the mental health team. The ACCT had been open only a few hour and caremap actions had not been completed. Just a few hours before he had harmed himself by banging his head on the segregation unit wall at Kirkham. We consider that the action of closing the ACCT and simultaneously making an urgent mental health referral appears contradictory. Although she had spent some time reviewing him, the SO did not know the man. She should have involved mental health staff in the ACCT review and should have left the ACCT open, at least until the mental health assessment.

76. The SO told the investigator that she believed that an ACCT had been opened for the man by staff at Kirkham as a precaution. She did not appear to have read the information in the ACCT document about his risks and instead based her decision on his demeanour and the fact that he told her he did not intend to harm himself.

77. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures and PSI 74/2011, about early days in custody, both list a number of risk factors and potential triggers for suicide and self-harm. The man had a number of these at the time of his reception into Risley, including a diagnosis

of a serious mental illness, a transfer from another prison and the fact that he had recently harmed himself. Staff at Kirkham, who were concerned about his risk to himself, had opened the ACCT just that morning. There is little evidence that the SO took any of these factors into account when assessing the man's risk of suicide and self-harm or that Risley had not been his preference for a move. The SO appears to have taken his assertion that he had no thoughts of suicide or self-harm, at face value. We make the following recommendation:

The Governor should ensure that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

- **Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs, medical records and ACCT documents.**
- **Ensure that they do not close an ACCT when a prisoner has recently self-harmed, expressed recent intent of suicide or self-harm, or has other significant risk factors.**

ACCT procedures

78. At Kirkham, the man told staff that he was not coping and felt unsure about whether he might harm himself or others. The staff appropriately opened an ACCT to provide additional support at the prison and for his transfer and early days at Risley.

79. After the SO in reception at Risley closed the ACCT at a review on 16 May, a nurse who saw him immediately after, opened the ACCT again. Staff were required to monitor the man every hour. An SO held an ACCT case review on Saturday 17 May. The review considered that he was at raised risk of suicide and self-harm and continued to require staff to observe him hourly. The SO noted that his offender supervisor and someone from the mental health team should attend the next review. He did not review or update the caremap with actions to help him and reduce his risk. Although a chaplain was present at the review on 17 May, neither of the ACCT reviews included anyone from the healthcare team, despite the man's mental health problems.

80. On Monday 19 May, a prison chaplain was very concerned about the man's state of mind and safety. He tried to persuade staff to hold an ACCT review that day, to review the man's risk and ensure he received appropriate support. The chaplain raised his concerns with a member of staff in the safer custody department who then asked the man's offender supervisor to hold a review. The offender supervisor decided that the review could wait until the next day. She did not go to see the man and did not speak to the chaplain. During the afternoon, the man's sister had spoken to the chaplain who was worried about him. The offender supervisor does not appear to have taken the man's vulnerabilities fully into account.

81. The chaplain was concerned about the offender supervisor's decision and spoke to the orderly officer, as the Head of Safer Custody had advised. The chaplain and the orderly officer gave different accounts of their conversation. The chaplain said that he told the orderly officer about his concerns and that he believed that the man needed to have an ACCT review urgently. The orderly officer said that the chaplain had not asked her to hold a review, but they had talked about him wanting to go to the segregation unit, which she said was inappropriate. She said that after she spoke to the chaplain, she spoke to officers on D wing to check what was happening with the man. We have been unable to confirm this and it appears that she might have confused the staff she spoke to with those on duty on the wing later. The orderly officer visited D wing at about 6.30pm to see another prisoner, but did not go to see the man or make an entry in his ACCT document about the discussions she had had about him.

82. We consider that staff should have held an ACCT review in response to the chaplain's representations. PSI 64/2011, which covers ACCT procedures, says that in addition to planned case reviews, a case review should be held when an ACCT trigger is activated or there are other concerns (including from families and other external parties) about a prisoner's risk. It is evident that the chaplain had significant and well-documented worries about the man's risk that day, yet managers did not respond to them appropriately. Neither the offender supervisor nor the orderly officer went to see the man. The Head of Safety Custody left the decision about whether to hold an ACCT review to the orderly officer.

83. ACCT entries over the weekend were mainly observational with little evidence of effective engagement with the man to support him. We are concerned that, on the afternoon of Monday 19 May, staff did not record hourly observations in his ACCT document, as they were required to do. There was a gap of over three hours between an entry at 2.55pm and one at 6.00pm. When Officer C found him unresponsive in his cell at 8.40pm the previous entry had been made at 7.00pm. The officer who made the 7.00pm entry was not the person who had observed him, who had been conducting a roll check. We doubt that a roll check of all prisoners can amount to an appropriate ACCT observation. We do not know whether an earlier check at the required frequency would have saved him.

84. We also have doubts about the accuracy of the ACCT entries on the afternoon of 19 May, which described the man as calm and quiet. This is in direct contradiction to the accounts staff gave about his behaviour that day and causes us to question the validity of the ACCT record. We note that there were many occasions when staff who were involved in discussions about his care did not record these in the ACCT document as we would expect.

85. Overall, the investigation identified a number of serious failings in the application of ACCT procedures which the prison will need to address. We make the following recommendation:

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

- **Completing ACCT documents fully and accurately and in accordance with mandatory requirements;**
- **Holding multi-disciplinary case reviews which include all relevant people involved in a prisoner's care;**
- **Setting and reviewing realistic goals in caremaps aimed at reducing the prisoner's risk;**
- **Arranging additional case reviews when there is information, or staff observe changes in a prisoner's behaviour, which indicates an increase in the risk they pose to themselves; and**
- **Carrying out and recording observations at the required frequency.**

Emergency response

86. When Officer C found the man lying on the floor in his cell he radioed for assistance, but did not use a code blue (signifying a life-threatening medical emergency such as where a person is found hanging, unconscious or not breathing). The officer told the investigator that it was not until he was in the cell that he was clear that the man was unconscious. However, he was evidently unresponsive and the officer was concerned enough to want to go into his cell immediately. He had seen a leather strap around the bed frame leading to the man's neck and he believed that he had referred to a ligature in his radio message for assistance.

87. Prison Service Instruction (PSI) 3/2013 about emergency codes, notes that local instructions should make it clear to staff that if they are in doubt about the nature of an injury, they should call an ambulance by using an emergency code. It notes that it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required. Had Officer C called a code blue immediately, it would have made the nature of the emergency clearer to those responding and should have resulted in the prison's control room calling an ambulance immediately. We make the following recommendation:

The Governor should ensure that staff use the appropriate emergency code whenever they have serious concerns about the health of a prisoner.

88. At night, officers on wings do not carry standard keys, but have a cell key in a sealed pouch for use in an emergency. National Prison Service instructions in PSI 24/2011 say that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are expected to make a rapid dynamic risk assessment of the situation.

89. It is sometimes difficult for staff in such situations to make immediate decisions, but when someone is in a potentially life threatening situation, it is essential to act quickly. In such circumstances we would normally expect staff to go into a cell as soon as possible, in case there is a chance of saving someone's life. Officer C knew that the man had been identified as at risk of suicide and self-harm, was unresponsive and appeared to have tied a ligature to his neck. He was prepared to go into the cell on his own, but unfortunately the orderly officer instructed him not to.

90. We consider that as Officer C was on the scene he was best able to assess the situation and should have had the confidence to act on his judgement. But, we recognise that it would have been difficult for him to ignore the night orderly officer's instruction. In the event there was relatively little delay, as Officer D arrived quickly. However, when dealing with a ligature incident, even a very slight delay can be crucial. In this case the indications are that it would have been too late to save the man, but we are concerned that the night orderly instructed Officer C to wait. We make the following recommendation:

The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life.

91. When both officers went into the man's cell and found he was not breathing they tried to resuscitate him. The officers told the investigator that they had previously had first aid training, but this was when they had first trained many years before. Both said that they attempted to resuscitate him but were unsure about what they were doing. We are satisfied that the officers acted appropriately in the circumstances and that nurses arrived quickly. However, it is important that there are sufficient officers on duty at all times who feel confident to initiate basic emergency treatment until trained staff arrive. We note that at the last two inspections of Risley, HM Inspectorate of Prisons found that, although nurses were trained in basic life support, there were insufficient trained officers. We make the following recommendation:

The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that all officers understand how to begin basic life support until trained staff arrive.

Reporting concerns about the welfare of a prisoner

92. The man's sister did not find out that he had moved to another prison until she went to visit him at Kirkham. When she spoke to the chaplain on Monday afternoon she was very distressed and explained that she had been trying to report concerns about his welfare since early that morning. His sister believed that the fact that the man had not contacted her since his move reflected a deterioration in his mental health.

93. We understand that staff were wary about passing the details of the whereabouts of the man to someone over the telephone. However, when a family member is trying to pass on concerns about a prisoner's welfare they

should act on that, wherever the prisoner is being held, and ensure that the information is passed on quickly. The Head of Safer Custody told the investigator that there is also a dedicated telephone line and an email address for family and friends to use to report concerns about a prisoner. However, none of the staff the man's sister spoke to told her about this telephone line or email address. We make the following recommendation:

The Governor should ensure that any concern about a prisoner from families and other external sources is accurately recorded and acted on quickly and that the telephone line and email address to report concerns about a prisoner's welfare is appropriately publicised to staff and the public.

RECOMMENDATIONS

To HMP Haverigg

1. The Head of Healthcare at HMP Haverigg should ensure that prisoners diagnosed with serious mental illnesses have well coordinated and effective care plans to facilitate appropriate continuity of care including psychiatric input when necessary.

To HMP Risley

2. The Head of Healthcare should ensure that there is sufficient dedicated mental health capacity at weekends and bank holidays to support prisoners assessed as at risk of suicide and self-harm because of mental health problems.

3. The Head of Healthcare should ensure that healthcare staff actively follow up prisoners with mental health problems, identified as at risk of suicide or self-harm, when they do not attend planned healthcare appointments or collect their prescribed medication.

4. The Governor should ensure that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

    - Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs, medical records and ACCT documents.
    - Ensure that they do not close an ACCT when a prisoner has recently self-harmed, expressed recent intent of suicide or self-harm, or has other significant risk factors.

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

    - Completing ACCT documents fully and accurately and in accordance with mandatory requirements;
    - Holding multi-disciplinary case reviews which include all relevant people involved in a prisoner's care;
    - Setting and reviewing realistic goals in caremaps aimed at reducing the prisoner's risk;
    - Arranging additional case reviews when there is information, or staff observe changes in a prisoner's behaviour, which indicates an increase in the risk they pose to themselves; and
    - Carrying out and recording observations at the required frequency.

6. The Governor should ensure that staff use the appropriate emergency code whenever they have serious concerns about the health of a prisoner.

7. The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life.

8. The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that all officers understand how to begin basic life support until trained staff arrive

9. The Governor should ensure that any concern about a prisoner from families and other external sources is accurately recorded and acted on quickly and that the telephone line and email address to report concerns about a prisoner's welfare is appropriately publicised to staff and the public.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare at HMP Haverigg should ensure that prisoners diagnosed with serious mental illnesses have well coordinated and effective care plans to facilitate appropriate continuity of care including psychiatric input when necessary.	Accepted	Steps have been taken which has resulted in a high proportion of those prisoners with a diagnosed serious mental illness have well co-ordinated and effective care-plans, facilitating appropriate continuity of care. Plans are in place to increase resources via commissioners, to create this for all prisoners. Such prisoners, when necessary, will receive forensic psychiatrist input.	Head of Healthcare 1st April 2015, dependent on ability to recruit to post	
2	The Head of Healthcare should ensure that there is sufficient dedicated mental health capacity at weekends and bank holidays to support prisoners assessed as at risk of suicide and self-harm because of mental health problems.	Accepted	NHS England will be contacted to discuss this recommendation. Extra funding will be needed to increase capacity particularly at weekends. To increase on site mental health provision during a weekend without an increase in capacity will mean reducing service provision during weekdays. In the meantime, on call arrangements will continue, and all case managers will be made fully aware of this service.	Head of Healthcare 28th February 2015	
3	The Head of Healthcare should ensure that healthcare staff actively follow up prisoners with mental health problems, identified as at risk of suicide or self-harm, when they do	Accepted	A process will be introduced that highlights offenders who are at risk of suicide or self harm and have recorded mental health problems, who have either missed collection of medication or healthcare appointments, that will then see a nurse follow up and identify reasons why, and if appropriate take action.	Head of Healthcare 14th February 2015	

	not attend planned healthcare appointments or collect their prescribed medication.				
4	The Governor should ensure that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should: • Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs, medical records and ACCT documents. • Ensure that they do not close an ACCT when a prisoner has recently self-harmed, expressed recent intent of	Accepted	An aide memoire will be produced for all case managers that will prompt them to consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self harm. Guidance will be sent out to all case managers reminding them that they should not close an ACCT until a multi-disciplinary case review has deemed that it is safe to do so.	Head Of Safer Custody 28th February 2015	

	suicide or self-harm, or has other significant risk factors.		The Safer Custody Team now produce a newsletter which informs staff of new initiatives, current themes etc. The next edition of this will focus mainly on the learning from this death. This is produced Bi-monthly, is emailed to all staff, published on the intranet and printed out and delivered to all relevant areas.		
5	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: • Completing ACCT documents fully and accurately and in accordance with mandatory requirements; • Holding multi-disciplinary case reviews which include all relevant people involved in a prisoner's care; • Setting and reviewing realistic goals in caremaps aimed at reducing the prisoner's risk; • Arranging additional case reviews when	Accepted	The Safer Custody CM has introduced revised ACCT quality checks, this identifies any issues with the completion of mandatory requirements of the ACCT process and this is then raised with the staff involved. A meeting will be arranged with Case Managers and learning points from the man's death will be discussed, this will then be put into guidance which will be sent to all present case managers and new case managers when appointed. The need to hold multi-disciplinary case reviews, including all relevant people involved in a prisoner's care and the need to set realistic goals in caremaps aimed at reducing the prisoner's risk will be highlighted in this meeting and form part of the above guidance.	Head of Safer Custody 28th February 2015	

	there is information, or staff observe changes in a prisoner's behaviour, which indicates an increase in the risk they pose to themselves; and • Carrying out and recording observations at the required frequency.		Guidance in relation to additional case reviews will be produced and sent to all staff, indicating that when there is information, or staff observe changes in a prisoner's behaviour, which indicates an increase in the risk they pose to themselves they should arrange an additional case review as soon as possible. Guidance will also sent out to all Custodial Managers and Offender Supervisors of the need to conduct additional reviews when requested. Guidance in relation to carrying out and recording observations was sent out soon after the death of the man; these will be reviewed and resent out to all staff. The Safer Custody now produce a newsletter which informs staff of new initiatives, current themes etc. The next edition of this will focus mainly on the learning from this death. This is produced Bi-monthly, is emailed to all staff, published on the intranet and printed out and delivered to all relevant areas.		
6	The Governor should ensure that staff use the appropriate emergency code whenever they have serious concerns about the health of a prisoner.	Accepted	A Notice to Staff will be published and emailed to all staff informing them of the appropriate emergency codes to use, this will be done annually. A number of "flash cards" informing staff of the codes have been handed out to staff and this will form part of an annual reminder to staff. The Safer Custody Manager will conduct an audit of all areas to ensure that it is advertised to staff where prisoners are likely to be.	Head of Safer Custody 28th February 2015	

7	The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life.	Accepted	A Notice to Staff will be published and emailed to all staff informing them of this guidance. The Safer Custody now produce a newsletter which informs staff of new initiatives, current themes etc. The next edition of this will focus mainly on the learning from this death. This is produced Bi-monthly, is emailed to all staff, published on the intranet and printed out and delivered to all relevant areas.	Head of Safer Custody 28th February 2015	
8	The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that all officers understand how to begin basic life support until trained staff arrive	Accepted	There is currently a first aid assessment of needs that identifies key individuals from varying areas to be trained in either First Aid at Work (FAW) or Emergency First Aid at Work (EFAW). There are a number of staff trained to cover day and night provision, we also have an on site provider who covers the provision of prisoners health. A further review of this provision will take place in light of this recommendation and appropriate actions taken. The suggestion that all officers on duty be familiar with basic life support has been considered nationally and the POELT training will be amended in 2015 to include a one day emergency first aid course, an element of which will include resuscitation and basic life support.	Health and Safety Lead 31st January 2015	
9	The Governor should ensure that any concern about a prisoner from families and other external sources is accurately recorded and	Accepted	We are altering our phone message on the main switchboard. If a member of the public, prisoners' family or any other external sources has concerns about a prisoner the message will direct them to Safer Custody's keep safe	Head of Safer Custody 28th February 2015	

	acted on quickly and that the telephone line and email address to report concerns about a prisoner's welfare is appropriately publicised to staff and the public.		line or the Orderly Officer or Duty Governor if they have urgent concerns, effectively this will allow for 24 hour cover. The Safer Custody Manager will conduct a review of the available publicity to ensure that it is appropriate and reflects the new message.		