PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Manchester in July 2014

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 died at HMP Manchester in July 2014 of ischaemic heart disease. He was 37 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Manchester was undertaken. Staff at Manchester co-operated fully with the investigation. There was initially some uncertainty about the cause of his death and the investigation was suspended until the post-mortem and toxicology examinations were concluded. I regret the consequent delay in issuing this report.

The man was diagnosed with schizophrenia and had spent time in acute psychiatric units. He had been in prison a number of times and had previously been identified and monitored as at risk of suicide and self-harm. During the three weeks he was at Manchester before his death, he had suffered from symptoms of drug withdrawal. An officer found him unresponsive in his cell. As he had been regarded as at risk of suicide and self-harm, the possibility that his death was from a drug overdose was considered. However, post-mortem examinations found that he had severe, undiagnosed, ischaemic heart disease.

The man's death was sudden and unexpected and I am satisfied that he received an appropriate standard of healthcare at Manchester. Although his death was from natural causes, the investigation identified some deficiencies in the operation of suicide and self-harm prevention procedures, which the prison will need to address. While it would not have affected the outcome for him, there is a need to improve emergency response procedures. I am also concerned that contact with his family was not as good as it should have been.

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 **February 2015**

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SUMMARY

1. The man was remanded to HMP Manchester on 30 June 2014. He had a longstanding diagnosis of schizophrenia and was prone to relapses. He had been admitted to psychiatric units several times and had harmed himself. He had spent a number of previous periods in prison, including three months in Manchester in 2013, when he lived in the prison's inpatient unit because of mental health problems. Staff monitored the man under Prison Service suicide and self-harm prevention procedures (known as ACCT).

2. Court staff had highlighted the man's risk of suicide and self-harm when he arrived at the prison in June 2014, but no one began ACCT procedures, as they thought that he seemed well. He had substance use problems and began a methadone maintenance programme.

3. The man appeared mentally well in his first weeks at Manchester, but said he suffered from drug withdrawal symptoms and that his methadone dose was not high enough. On 16 July, a nurse started ACCT procedures when he said he could not cope. A substance misuse doctor increased his methadone dose but staff at an ACCT case review did not fully consider all of his concerns.

4. An officer found the man unresponsive during a check at night. The officer did not call for help as quickly as he should have done and no one tried to resuscitate him until the response nurse arrived, around four minutes later. However, it seems likely that he had already died. Paramedics pronounced him dead shortly after they arrived.

5. We are satisfied that the man died from heart disease, which the prison could not reasonably have predicted or prevented. However, the investigation found a need for some improvements in the operation of ACCT procedures. While these matters had no bearing on his death, it is important that they are addressed to help prevent future deaths. Although it would not have affected the outcome for him, the emergency response procedures were not in line with local and national instructions. The prison did not inform his family of his death as quickly as they should have done. We make three recommendations.

THE INVESTIGATION PROCESS

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

7. The investigator visited Manchester on 25 July 2014. He met the Governor and the prison's family liaison officer. He viewed CCTV coverage of the night of 20 July and obtained copies of the man's prison records.

8. The investigator wrote to the man's cellmate, who was released on 21 July, to ask him to participate in the investigation, but he did not reply. Greater Manchester Police provided a transcript of an interview with him.

9. The man interviewed 21 members of staff and three prisoners at the prison in September and October. He telephoned a former prisoner, who the man's family said had relevant information, but he did not reply.

10. NHS England commissioned a clinical reviewer to review the man's clinical care in prison. He joined the investigator for some of the interviews.

11. We informed HM Coroner for the City of Manchester of the investigation, who provided the results of the post-mortem examination and toxicology. Our investigation was suspended until these examinations were concluded. The suspension was lifted on 20 November when we received the final post-mortem report and toxicology from the Coroner. We have sent the Coroner a copy of this report.

12. The investigator and one of the Ombudsman's family liaison officers visited the man's parents on 27 August. They had the following issues they wanted the investigation to address:

- Their son had lived on the healthcare unit when in Manchester in 2013. His family wanted to know why he had not done so in 2014.
- The family asked for more details about his medication, including why he had been prescribed methadone when he was not prescribed it in the community and whether blood tests were taken to establish the correct management of his clozapine.
- The family asked why the prison did not facilitate a telephone call to them, as they could have given him support.
- Another prisoner had told them that their son had fallen asleep at dinner on the day he died, had seemed stressed, and had received a note from a chaplain saying he should contact his parents as soon as possible. (The prisoner did not respond to us.)
- His family wanted more details about the night he died.
- The man's parents were concerned about the length of time it took to tell them of their son's death and did not consider that the prison followed the correct procedures.

13. The family received a copy of the draft report. They did not make any comments.

HMP MANCHESTER

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

HM Inspectorate of Prisons

15. The report of the most recent inspection of HMP Manchester in November 2014 has yet to be published but in feedback to us, inspectors reported that, in terms of safety, outcomes for prisoners were good. The safer custody group had worked with the University of Manchester to pilot an intervention for prisoners at risk of suicide, and prisoners on ACCT support were positive about their care. Inspectors found that Manchester had incorporated the response to PPO recommendations from previous deaths into a consolidated action plan, but some recommendations about healthcare had not been fully achieved. These included recommendations about resuscitation, prescribing methadone alongside other sedative medications and training for the symptoms of drug-induced unconsciousness. Inspectors found that clinical support services for prisoners with substance use problems were good. Overall, health care services were good and the integrated mental health service provided a good service.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2014, the IMB reported that the service provided to mental health patients had improved. They found an increase in the number of ACCTs opened in the reporting year and they were completed to a good standard.

Previous deaths at HMP Manchester

17. We investigated four deaths at Manchester in the two years before the man died and one since. We made several recommendations about the ACCT process and, in one investigation, we found that the risk of suicide or self-harm was not adequately assessed in reception. Where relevant, we found that the men received appropriate mental health care and treatment for substance misuse problems. In two investigations, we found unnecessary delays in breaking the news of the death to the next of kin.

KEY EVENTS

18. The man spent several periods in prison from the late 1980s. When he was 18, he was diagnosed with schizophrenia and prescribed clozapine to control this. He had a history of substance misuse which, in turn, affected his mental health, and had diabetes and asthma. Reports indicate that he had harmed himself several times in the past.

19. The man was sent to HMP Manchester in June 2013 and was monitored under ACCT procedures at the time. (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.) A prison psychiatrist noted that his mental health appeared to have relapsed because of recent drug use and he was admitted to the prison's inpatient unit. After a court appearance on 28 August, he was admitted to hospital under the Mental Health Act. He was discharged into the community on 30 December.

20. On 30 June 2014, the man was convicted of burglary at Manchester Magistrates' Court and remanded to HMP Manchester until he was sentenced. When he arrived at the prison, there was a suicide and self-harm warning form from court indicating that he appeared to be withdrawing from drugs, seemed depressed and had signs of mental disorder. His escort record also recorded that he had attempted to hang himself in 2012 and had been diagnosed with schizophrenia and depression.

21. When the man arrived at the prison, a nurse noted his mental and physical health history and his current medication. He said that he used various drugs illicitly, including methadone (usually prescribed as a substitute for heroin), diazepam (a sedative) and cocaine. The nurse referred him to the Substance Treatment and Recovery (STAR) team and the mental health in-reach team.

22. The nurse offered to admit the man to the healthcare inpatient unit, but he declined, without giving a reason. Despite the suicide and self-harm warning form, the nurse did not open an ACCT as the man said he did not feel like harming himself and he did not appear suicidal. An officer interviewed him in reception and also concluded that, as he did not seem anxious or in a low mood, he did not need to be managed under ACCT procedures.

23. The man told the reception GP and a nurse from the STAR team that he usually bought 50ml of methadone a day, which he had last used the day before. The nurse assessed him using the Clinical Opiate Withdrawal Scale (COWS), on which he scored one. A score of 13 or more would indicate the need for immediate treatment. He scored 13 on the Clinical Institute Withdrawal Assessment for Benzodiazepines (CIWA-B), for which the threshold for treatment is 30. The GP prescribed the medication that the man had received in the community, which healthcare staff confirmed with his community GP, although he asked the STAR team to review his prescription of diazepam. The man went to I wing, the first night and induction unit for prisoners needing substance use treatment.

24. The next morning, 1 July, the man told the nurse from the STAR team at a secondary health screen that he had withdrawal symptoms. His score on COWS had gone up to 13 and to 27 on CIWA-B. The duty STAR doctor assessed him later that morning, who now said that he had usually used between 10ml to 15ml methadone each day. The doctor prescribed 10ml of methadone that day, rising to 15ml the next day to reflect what he had said he had been using in the community. He prescribed 5mg of diazepam a day as his community GP had prescribed it.

25. A nurse from the mental health in-reach team assessed the man that afternoon, after his community psychiatric nurse had briefed her. She concluded that he had no current symptoms of mental illness and appeared to be coping well.

26. Anyone prescribed clozapine must have monthly blood tests to check the effect on their white blood cells. Blood tests on 2 July indicated that it was safe to continue the current dose of clozapine.

27. On 3 July, the man said he was suffering withdrawal symptoms from methadone and diazepam and COWS and CIWA-B assessments, scored 12 and 34 respectively. The duty STAR doctor increased the man's diazepam to 10mg per day and kept his methadone at 15ml. On 5 July, he said he was still experiencing withdrawal symptoms. A nurse noted that the man was visibly sweating, assessed his COWS score as 14 and booked him to see the STAR team doctor the next morning.

28. On 6 July, the man told a doctor that he had stomach cramps and nausea. The doctor increased the methadone to 20ml per day but noted that this was the maximum he should get at the time. The doctor told the investigator that this was because the man was prescribed a lot of other medications and he thought he should stabilise on a low dose, but did not regard 20ml as a fixed limit. The doctor thought that they should be flexible if his symptoms later indicated a need for an increase. He did not note this in the medical record at the time.

29. On 8 July, the man moved to H wing, a specialist wing for prisoners receiving drug treatment, who have completed their induction. He shared a cell with another prisoner. On 9 July, he told a nurse that he was suffering a bad withdrawal and the nurse noted that he was visibly sweating. The man was concerned that his mental health was deteriorating and said he had ringing in his ears and was sensitive to light. The nurse told us that these symptoms related to his withdrawal and were not symptoms of psychosis.

30. The man told the nurse that his offender manager (probation officer in the community) had suggested that he might transfer to a psychiatric hospital rather than stay in prison. The nurse told us that she thought that he did not need hospital admission as he had very good insight into how to manage his mental health, and had been well enough to live in his own home in community. The man said that he was stressed about an upcoming hearing

on 21 July about the custody of his daughter and was worried that he might not be able to see her again.

31. On 14 July, the man appeared at Crown Court and was remanded back to the prison for sentencing in August. That evening, he told a nurse that he did not feel well and that his methadone prescription "was not holding him". He said that he was sweating, but the nurse saw no sign of sweat anywhere else on his body except his face. She suspected the man might have splashed water on his face in an attempt to have his dose increased. His COWS assessment score was eight. He had an appointment with the STAR doctor for 24 July and she told him to tell a member of staff if his symptoms got worse before then.

32. On 16 July, the man told a nurse that his methadone prescription was insufficient and he "did not want to be here anymore". The nurse noted that he looked unwell and his mood was noticeably lower than when she had last seen him. She opened an ACCT, as she was concerned that he might harm himself. They discussed whether the man should be admitted to the healthcare inpatient unit, but agreed that this would be counterproductive as he said his cellmate was very supportive. The nurse noted that he was stressed about his daughter's custody hearing.

33. A prison psychiatrist saw the man for a pre-planned review that day. He said he felt anxious, sometimes heard voices and was not coping well with his methadone programme. He said his family and daughter were important factors in his life but that things had gone downhill since his daughter had been taken into care. The man did not want her to be adopted. He said he had no intention to harm himself. The psychiatrist increased his diazepam and mirtazapine (anti-depressant) prescriptions and noted that the man did not want to be admitted to the healthcare unit.

34. At an ACCT assessment with an officer on 16 July, the man said that his main issue was his methadone dose and he could not wait until his next review on 24 July. He said that he had no reason to live as his daughter was being adopted. The H Wing unit manager chaired the first ACCT case review that afternoon, with an officer, a member of the STAR team and a nurse from the mental health in-reach team. The man said that his main issue was his medication but that he did not intend to harm himself. The manager told us that they had discussed his daughter's adoption, but there is no mention of this in the record of the review. The review required staff to observe him five times during the day and five times at night.

35. The manager listed two issues on the ACCT caremap: the man's schizophrenia, and his methadone prescription. Another appointment with a nurse was arranged for 17 July and his review with the STAR doctor was brought forward to 18 July. In the meantime, he was prescribed additional medication to relieve his symptoms. The manager said they did not list the issue of his daughter's adoption as an issue on the caremap because it was not one the prison could resolve.

36. The nurse said that when she assessed the man on 17 July, he still appeared physically unwell. Although still in a low mood, he felt that people were listening to him and he knew he would soon have a methadone review. That afternoon, he phoned his parents and girlfriend.

37. On 18 July, at his review with the STAR doctor, the man told a doctor that he was finding it difficult on his current dose of methadone and was feeling sick and had stomach cramps. The doctor said that he looked very unwell and had a classic case of opiate withdrawal. He completed a COWS assessment, and the man scored 16. Because of his physical symptoms, the doctor increased his daily methadone dose to 30ml.

38. At around 9.00am on Saturday 19 July, an officer noted in the man's ACCT document that she had spoken to the man, who said that he wanted to speak to a chaplain about contacting his solicitor. She told us that she had telephoned a chaplain and thought that the chaplain visited him. (The chaplain thought he had seen him on 18 July, at the request of his solicitor but he had made no record of this either in the chaplaincy log or the ACCT document.) Later that afternoon, the man told an officer that he was applying for emergency telephone credit, which he would submit for processing on Monday morning. She told us that she thought this was related to speaking to his solicitor.

39. On the morning of Sunday 20 July, the man asked an officer if he was going to court the next day. The officer told him that wing staff did not have that information and he would be told early the next morning. The officer said that there was nothing about the man's physical or mental health that concerned him.

40. That afternoon, the man told an officer that he was going to court the next day about custody of his daughter. The officer told us that he seemed to be looking forward to having the custody issue resolved. The man asked about emergency telephone credit as he said he would want to speak to his family after he got back from court. The officer told him that his application could not be processed on a Sunday but it would be done by the time he got back from court. The officer said that the man was sweating when they spoke but it was a very hot day and everyone on the wing was feeling the heat.

41. At around 5.00pm, the man took his medication and collected his evening meal. He and his cellmate were locked in their cell for the night shortly afterwards. The cellmate told the police that the man was "whacked out" and fell asleep between 6.00pm-7.00pm, as he had done the previous four or five nights.

42. At around 6.20pm, Officer A began a night shift on H wing and started a security check of the wing. When he arrived at the man's cell at 6.40pm, he said that the man was asleep and that he had a brief conversation with the cellmate about this. He went back to the cell at 7.10pm for an ACCT check and found he was still asleep. The officer said that the man was lying on top of the covers with his clothes on and that he could see him breathing. At

7.50pm, he made one entry in his ACCT document to record these two observations and wrote, “He appears asleep lay on his front, clearly visible and movement noted”.

43. Closed circuit television (CCTV) of the wing shows Officer A next went to the cell at 10.25pm and looked through the observation panel for 40 seconds. He told us that the man was lying in a very similar position to before but there was something that did not look right. He asked the cellmate to check him, but he was unable to get any response. The officer said he could not see any sign that the man was breathing and was concerned that he might have died or have a serious medical problem.

44. Officer A ran to get help from two of his colleagues who were working on nearby wings. He said that he did not radio for urgent help immediately, as this was the quickest way to get other officers to attend so that he could open the cell. He did not think it was safe to open the cell on his own. He got back to the cell 20 seconds later, with his colleagues. He then radioed a ‘priority one’ call (the emergency code at Manchester indicating a life-threatening situation). At night, officers carry cell keys in a sealed pouch for use in an emergency. After a little difficulty opening the sealed pouches, which took 42 seconds, the officer went into the cell at 10.27pm and took the cellmate out.

45. Officer A examined the man. He said he could not find a pulse and his hands were cold, although his body was warm. He and a colleague that the man was dead. Thirty seconds after they opened the door, all the officers came out. No one began any basic life support.

46. At 10.29, two nurses arrived at the cell. Nurse A said that the man was quite warm, although his hands and elbows were cold and there was some indication of blood ‘pooling’ (where blood settles in the lower part of the body as the heart is no longer pumping it around the body) but no sign of rigor mortis. The nurses used a defibrillator, which found no shockable heart rhythm and they began cardiopulmonary resuscitation. Nurse B gave chest compressions and Nurse A rescue breaths. An ambulance crew arrived at the cell at 10.44pm and, shortly afterwards, confirmed that the man had died.

47. At around 11.40pm, the duty governor and a prison chaplain arrived at the prison. The police attend all deaths in prison and were already there. The duty governor told us that he wanted to start the risk assessment needed before visiting the man’s family to inform them of his death, but the lead police investigator vetoed this and said he needed to rule out ‘foul play’ first. He would then discuss how to break the news. The duty governor said that he explained that it was Prison Service policy to inform families promptly, but the police asked him to wait.

48. At around 5.00am, the police told the duty governor that the family could be informed. As he and the chaplain had now both been on duty for nearly 24 hours without sleep, the duty governor did not believe it was appropriate for them to go. He did not ask any other prison staff but asked the police to break the news.

49. At 8.45am, two police officers visited the man's parents and told them that he had died. The man's parents said that the police had no other details and did not have the name or number of anyone at the prison they could contact for information. His parents said that the timing of this visit was particularly distressing as they were about to leave for the custody hearing for their son's daughter. That afternoon, two prison family liaison officers visited them and offered condolences and explained what had happened.

50. Prisoners were informed of the man's death and told they could get support from Listeners (prisoners trained by the Samaritans to support other prisoners in distress) or the Samaritans if they needed it. Staff reviewed prisoners being monitored under ACCT arrangements in case they had been adversely affected by the news of his death. The man's cellmate had a cell with a Listener overnight. The next day he was released from prison at the end of his sentence.

51. The Governor debriefed the staff involved in the emergency response and offered them the support of the prison's staff care and welfare team.

52. The funeral took place on 1 August and the prison contributed to the costs in line with national guidance.

53. After his death, a prisoner told prison staff that the man had got drugs from another prisoner on the day he died. When we spoke to him, this prisoner said that this had not been true.

54. A toxicology test, as part of the post-mortem examination, found that the concentration of methadone, and possibly clozapine, in the man's blood could have posed a risk of toxicity. However, the pathologist found he had severe ischaemic heart disease and evidence of a previous heart attack. While the pathologist could not entirely exclude the possibility that the man died from multiple drug toxicity, he concluded that it was far more likely that his death was due to ischaemic heart disease.

ISSUES

Clinical care

55. The man's main concern while he was at Manchester was his methadone prescription. On several occasions, he told prison and healthcare staff that he was suffering from withdrawal symptoms and wanted a higher dose. Doctors increased his prescription when they considered it was necessary. The clinical reviewer found that methadone prescribing was consistent with established protocols and that his clinical treatment for substance misuse was appropriate.

56. The man had a history of schizophrenia for which he had been admitted to acute psychiatric units several times. A nurse told us that he was very insightful about his mental health and knew how to manage his schizophrenia. Unlike when he was at Manchester in 2013, she said that he was mentally well with no indication of psychosis and there was therefore no reason for him to be admitted to the healthcare inpatient unit. When his mood lowered around 16 July and he found it difficult to cope with his withdrawal symptoms, the staff offered to admit him as an inpatient but he turned this down as he said his cellmate gave him support. We are satisfied that there was no reason for him to be an inpatient.

57. The clinical reviewer concluded that the man received good mental health care at Manchester, with evidence of good care planning and communication between agencies. He also considered that clozapine was prescribed, administered and monitored in line with national prescribing guidelines.

58. The man had no recorded history of heart disease and there was no reference to such a diagnosis in his prison or community medical records. The post-mortem indicates that he had severe ischaemic heart disease with evidence of a previous heart attack. People with a history of substance misuse problems are at greater risk of heart disease, but this is difficult to detect. However, the clinical reviewer noted that the man was reasonably physically fit and there was nothing to indicate that any further checks were needed. We are satisfied that there was nothing healthcare staff at the prison could have done to predict or prevent his death.

Management of risk of suicide and self-harm

59. Although the man's death was from natural causes, the investigation identified some concerns about assessment of risk and management of ACCT suicide and self-harm procedures. When he arrived at the prison, he had a number of risk factors for suicide and self-harm, including previous self-harm, a diagnosis of schizophrenia, previous admissions to psychiatric hospitals, and he was withdrawing from drugs. A suicide and self-harm warning form and the man's escort record highlighted these risk factors. However, reception staff did not open an ACCT because the man said he did not have thoughts of suicide or self-harm and because he did not appear to be in a low mood. The reception nurse said he had had no formal ACCT training and the reception

officer said it was some years since he had been trained. Both seemed unsure about assessing risk.

60. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered. We are concerned that staff did not fully consider the man's significant risk factors and balance them against his presentation, a matter we have identified in previous investigations into deaths at Manchester.

61. Prison staff began monitoring the man under ACCT procedures on 16 July. They identified his main concern as his methadone programme. Although he was very upset about a forthcoming hearing about his daughter's custody, there is no record of discussion about this at the ACCT review. It was not included as an issue on his caremap, apparently because this was not something the prison could resolve. We accept that prison staff cannot influence the outcome of court custody hearings but the ACCT review and caremap should have identified ways to support him, including helping him contact his family and solicitor.

62. Although the case review on 16 July assessed the man's level of risk of suicide and self-harm as raised, the staff set the level of observations at five a day and five at night. We do not consider this reflected the perceived level of risk and meant that officers were not required to check him for several hours. Although not an issue on the night that he died, we also note that this level of observation was not always recorded at night. Officer A recorded five observations on the night of 16 July, but only four on the following three nights. He said this was because staff on the day shift had made late entries. On 20 July, he checked the man at 7.10pm, but did not record this until 7.50pm. Prison Service Instruction 64/2011 says that observations "must be recorded immediately or as soon as practicable thereafter".

63. While these matters did not affect the outcome for the man, it is important that staff follow agreed procedures for managing prisoners at risk of suicide and self-harm. 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:

- **Fully considering and recording all risk factors for newly arrived prisoners and opening an ACCT when indicated;**
- **Recording all relevant issues on the caremap and at ACCT reviews;**
- **Setting a level of observations that reflect the perceived level of risk;**
- **Completing ACCT checks at the required frequency; and**
- **Recording ACCT observations immediately or as soon as possible after they are made.**

Emergency response

64. PSI 03/2013 *Medical Emergency Response Codes,* issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on 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 stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Manchester's local guidance (Governor's Order 17/2014) instructs the use of the emergency code 'priority one' when a prisoner is found unconscious or with life threatening injuries.

65. Although Officer A realised that there was a serious problem when he arrived at the man's cell at 10.25pm, he did not make a 'priority one' radio call but went to get other officers. While there was only a very short delay, he should have radioed an emergency call first, which would have alerted staff throughout the prison, including the response nurse and have signalled to the control room to call an ambulance immediately.

66. None of the officers who went into the man's cell tried to resuscitate him, but waited for nurses to arrive. None of them had up to date first aid training. Resuscitation Council (UK) guidelines state that resuscitation should be carried out until qualified help arrives (meaning either a doctor or paramedic) unless resuscitation is impossible because there are clear signs of rigor mortis, which was not the case. It is important that staff begin cardiopulmonary resuscitation as soon as possible to improve the chances of survival unless there are clear signs of death, which would indicate that resuscitation would be futile. We make the following recommendation:

    The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that staff call an emergency medical code immediately in a potentially life threatening situation and administer basic life support as needed until healthcare staff arrive.

Family liaison

67. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies. PSI 64/2011 gives a mandatory instruction that, wherever possible, this must be done in person by a family liaison officer and another member of staff. The duty governor said that the police said that he could not inform the man's family until they completed their enquiries. When, at 5.00am, the police said that he could now break the news of his death, he asked the police to do so because of the excessive length of time he had been at work. It was not until 8.45am that police officer informed the man's parents. Apparently, they had little other information.

68. The man's family were understandably upset about the delay and how the news was broken to them. Although we acknowledge that the duty governor had been put in a difficult position, the then Governor told us that he would

have overruled the police had he known and would ensure that, in future, the police were aware that it was the prison's responsibility to inform the bereaved family as soon as possible.

69. It was nearly four hours after the police had agreed that the man's family could be informed of his death that his parents, who live just a few miles from the prison, were told. We appreciate that the duty governor and chaplain had had a long night, but national instructions are clear that, wherever possible, someone from the prison should visit in person the next of kin or other nominated person to break the news of a death. No thought appears to have been given to asking another member of staff to visit them. This meant that they had very little understanding of what had happened and the police were unable to answer any of their questions. We make the following recommendation:

The Governor should ensure that a member of Prison Service staff informs a prisoner's family of their death quickly and in person, in line with national guidance.

RECOMMENDATIONS

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

    - Fully considering and recording all risk factors for newly arrived prisoners and opening an ACCT when indicated;
    - Recording all relevant issues on the caremap and at ACCT reviews;
    - Setting a level of observations that reflect the perceived level of risk;
    - Completing ACCT checks at the required frequency; and
    - Recording ACCT observations immediately or as soon as possible after they are made.

2. The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that staff call an emergency medical code immediately in a potentially life threatening situation and administer basic life support as needed until healthcare staff arrive.

3. The Governor should ensure that a member of Prison Service staff informs a prisoner's family of their death quickly and in person, in line with national guidance.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: • Fully considering and recording all risk factors for newly arrived prisoners and opening an ACCT when indicated; • Recording all relevant issues on the caremap and at ACCT reviews; • Setting a level of observations that reflect the perceived level of risk; • Completing ACCT checks at the required frequency; and • Recording ACCT observations immediately or as soon as possible after they are made.	Accepted	The Governor will ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In respect of your five bullet points: • Reception and induction staff will be refreshed in ACCT awareness training. Safer custody will publish guidance on recognition of historical risk factors in newly arrived prisoners. • Safer custody will produce guidance to all case managers on use of the care map, reviewing of triggers and evidencing that the risk factors have been reviewed. • Levels of observations will continue to be set to reflect the perceived level of risk. In the man's case, the multi-disciplinary case review team was satisfied that they assessed his risk factors and agreed the level of monitoring, as per PSI 64/2011 and the ACCT guidance notes. • A notice to staff (NTS) will be issued reminding staff of the importance of completing checks at the right frequency. ACCT management and checks will form part of wing briefings to staff. Quality assurance checks will take place. • A NTS will be issued reminding staff of the importance of recording observations immediately, or as soon as possible, after they have been made.	30 April 2015 Head of Residence Head of Safer Custody Custodial Manager in Safer Custody Safer Custody Manager

2	The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that staff call an emergency medical code immediately in a potentially life threatening situation and administer basic life support as needed until healthcare staff arrive.	Accepted	Training for residential staff will be reviewed and all wings will have a minimum of four first aid trained staff. The emergency response protocol will be re-issued to all staff to remind them of the importance of calling an emergency medical code immediately in a potentially life threatening situation. Healthcare staff will also deliver emergency basic life support training to residential staff.	31 May 2015 Heads of Residence Safer Custody Manager
3	The Governor should ensure that a member of Prison Service staff informs a prisoner's family of their death quickly and in person, in line with national guidance.	Accepted	The family liaison officer and duty governors will be briefed to ensure that NOMS staff, and not the Police, inform a prisoner's family of their death at the earliest opportunity. Greater Manchester Police has also been advised that it should be prison staff that deliver this news to a prisoner's family. If support is required from Greater Manchester Police, this will be requested on an individual basis.	31 March 2015 Head of Safer Custody