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 & YOI Holme House in May 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 was found hanged in his cell in HMP & YOI Holme House in May 2014. He was 19 years old. I offer my condolences to the man's family and friends.

One of my investigators had conduct of this case. A clinical reviewer reviewed the man's clinical care in custody. HMP Holme House co-operated fully with the investigation.

The man was Eritrean and entered the United Kingdom illegally in 2013. In May 2014, he was charged with the murder of an Eritrean woman, who he may have been in a relationship with. The courts remanded him in custody and he arrived at Holme House on 6 May. Prison staff identified that he was at risk of suicide and self-harm and began to monitor him and staff observed him every hour. He did not speak or understand English well, but staff initially thought that they could get by without using an interpreter. For his first days at the prison he had a cell in the prison's healthcare centre, in case he needed extra support.

The man attended a court hearing on 7 May, but staff did not assess the impact on him when he returned, although they had identified court appearances as a potential trigger for suicide or self-harm. At a case review later that day, which did not use an interpreter, prison staff reduced the number of checks to three times during the day and once at night, The next day at another review, using an interpreter, it was agreed that he should move from the healthcare centre to the prison's induction unit. He mixed with other prisoners there, but language difficulties limited the extent of his interaction.

At about 8.30pm on 10 May, a prison officer checked the man. No one checked him again until 6.20am the next morning, when an officer found him hanged in his cell. It was evident that he had been dead for some time.

Prison reception staff rightly identified the man as at risk of suicide and self-harm, but I am concerned that they did not ask him if he needed an interpreter and relied on their own assessment of his understanding of English. Interpretation services were used only once after that, and I do not consider that the man was appropriately supported during his short stay at the prison. In particular, I am concerned that, despite his evident risk factors, staff assessed his risk of suicide and self-harm as low and reduced the level of observations too quickly. Even then, staff did not carry out the once nightly check on him that had been agreed.

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** **January 2015**

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## SUMMARY

1. On 6 May, the man arrived at Holme House, charged with the murder of an Eritrean woman. He was 19, in prison for the first time, and had no family support. He spoke only limited English, but staff did not use an interpretation service. Officers considered that his mood was low and that he had a number of factors that made him at risk of suicide and self-harm. They opened an ACCT, the Prison Service's care planning system to support such prisoners.

2. Prisoners arriving at Holme House, charged with murder, spend at least one night in the healthcare centre, for extra support. A senior nurse assessed the man, but did not use an interpreter. When she asked him about his alleged offence, he said that he did not understand. The nurse did not consider that he was at imminent risk of harming himself, so did not pursue this further. She decided that staff should check him at least once every hour.

3. The next day, 7 May, a multi-disciplinary panel, without using an interpreter, assessed the man's risk of suicide as low although there had been no change in his risk factors. The panel reduced the level of his observations to three times during the day and once during the night. On 8 May, another panel, this time using an interpreter, agreed that he was fit to move from the healthcare centre. Although the man's ACCT plan had identified that court appearances might be a trigger for suicide or self-harm, he was not assessed when he returned from court on 7 May and no action was taken in preparation for a scheduled court appearance on 12 May.

4. On 9 May, a family friend visited the man. Staff did not notice any problems during the visit, and a prisoner who returned to the houseblock with the man said he did not appear distressed. However, his visitor told us that the man had been upset and had cuts and bruising on his arm. His friend said that when leaving the visits hall he had told a prison officer, who had said he would take some action. We have not been able to establish who this officer was and there is no other record of this.

5. On Saturday 10 May, the man walked around the houseblock during an association period, played pool, and asked another prisoner to help him fill out some forms. After prisoners were locked in their cells for the evening, officers checked the man a few times, the last time at 8.38pm. They did not note any concerns. Although staff were supposed to check the man at least once during the night, no one checked him again until the next morning, nearly ten hours later.

6. At 6.21am the next day, an officer who was carrying out a roll check to ensure the correct number of prisoners were present in the houseblock, found the man hanged in his cell. He had tied a ligature made of a sheet to the bunk bed. The officer called an emergency code, went into the cell and cut the sheet from around his neck. Nurses arrived quickly, but did not attempt to resuscitate the man, as it was clear that he had been dead for some time.

7. The early days in custody are a critical time for any prisoner, particularly a young man like in this case, in prison for the first time, charged with a serious offence. Although prison staff appropriately identified the man's risk factors when he arrived at Holme House, we are concerned that they reduced his

assessed level of risk of suicide and self-harm to low too quickly, just a day after he arrived and set a low level of observations. Too little use was made of interpreters. We are concerned that on his last night, no one checked him at all. Although court appearances were listed as a possible trigger for self-harm, this did not result in any action. We make three recommendations.

## THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

9. On 14 May, the investigator spoke to prisoners at Holme House, visited the areas of the prison where the man had lived, and obtained copies of his prison record. He interviewed members of staff at Holme House in July and August. Two nurses were unavailable for interview because of ill-health. The investigator gave the Governor initial feedback about the preliminary findings of the investigation.

10. NHS England, Durham, Darlington and Tees Area Team, commissioned a clinical reviewer to review the man's clinical care at the prison. The clinical reviewer joined the investigator for interviews with healthcare staff.

11. We informed HM Coroner for Teesside of the investigation, who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted the man's cousin, who represented his family. He explained the investigation and asked the man's cousin to identify issues his family would like the investigation to consider. His cousin had the following questions:

    - What support measures were put in place for his cousin when he arrived in Holme House?
    - How did the prison address the fact that his cousin did not speak very good English?
    - What action did the prison take when his cousin's visitor on 9 May told a prison officer that he was very distressed and had signs of self-harm?
    - Why is prison bedding not made from non-rip material when prisoners often use ripped bedding to hang themselves?
    - Why was his cousin moved from the healthcare centre to the main prison despite his young age and poor understanding of English?

13. The man's family received a copy of the draft report. They raised some issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## HMP & YOI HOLME HOUSE

14. Holme House is a local prison for up to 1,212 men, including a small number of young adults between 18 and 21. The majority of prisoners are remanded into custody or have been recently convicted by local courts. Care UK provides health services at Holme House. Nurses are on duty 24 hours a day. There is a separate healthcare centre which can house 16 inpatients.

### Her Majesty's Inspectorate of Prisons

15. HM Inspectorate of Prisons most recently inspected Holme House in August 2013. Inspectors reported that the prison faced significant challenges, but had made some important progress. However, they were concerned that previous progress made in learning about risk indicators associated with self-inflicted deaths had not been sustained. Care for prisoners who had been assessed as at risk of suicide or self-harm was good. The report noted that, while Holme House had a good foreign national prisoner policy, foreign national prisoners were left to fend for themselves too often, with inadequate formal support. Inspectors found that professional interpreting services were used appropriately.

### Independent Monitoring Board

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In its annual report for 2013, the IMB wrote that in a year of significant changes Holme House remained a well-run establishment that had safety, security and the wellbeing of prisoners at its heart.

### Previous deaths

17. Five of the last six self-inflicted deaths at Holme House since November 2011 happened during the prisoner's early days at the prison. We have made a number of recommendations about the need for better assessment better assessment of risk factors for newly-arrived prisoners and improved support during the early days in custody.

### Assessment, Care in Custody and Teamwork

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## KEY EVENTS

19. The man came from Eritrea and entered the United Kingdom some time in the latter part of 2013. On 4 May, the police arrested him and charged him with the murder of an Eritrean woman in Middlesbrough. The courts remanded the man to custody and he arrived at HMP Holme House in the afternoon of Tuesday 6 May. He had no previous convictions in the United Kingdom, and his escort record did not include any warnings that he was at risk of suicide or self-harm.

20. When the man arrived at the prison, officers were concerned that he did not seem to understand why he was in prison. Because of this and the seriousness of the charge against him, they asked a reception nurse to see him, before they began their usual search and booking in procedures. A nurse assessed him and noted on his medical record that he did not use an interpreter as he had understood and participated easily. He told the nurse that he had never harmed himself and had no thoughts of suicide, as it was against his religion. The nurse was not concerned about the man's mental state. He did not report any significant medical history. He said that he was not taking any medication, and did not drink or use drugs. At Holme House, all prisoners charged with murder usually spend some time in the healthcare centre for an initial period of observation and the nurse noted that the man had agreed to this.

21. An officer then assessed the man. Guidance about the factors that can increase a prisoner's risk of suicide and self-harm is displayed in the reception area at Holme House as a reminder to staff. The officer noted that the man had a number of these: he was only 19 years old, was facing a charge of murder, and was in prison for the first time; all factors that increase risk He appeared to be in shock about being in prison, and was feeling in a low mood. The officer therefore began an ACCT plan at 6.10pm.

22. A further officer then spoke to the man, to give him some basic information about prison and about what would happen in his first few days. He noted that the man spoke little English. However, when interviewed, he said that although his English was not good, it was good enough for him to understand the simple information given to him. The officer did not think that he needed to use Language Line, (a telephone interpreting service) to speak to the man. He said that he had engaged with reception staff until they asked him about his alleged offence, after which he said that he did not understand.

23. A reception checklist indicated that staff had informed the foreign national clerk about the man. A personal summary sheet noted that he could read and write. He signed various prison induction documents and the officer countersigned them. The officer told the investigator that he was satisfied that the man had understood him and that he did not need to use Language Line. He then completed the Concern and Keep Safe section of the ACCT form. He noted that it was the man's first time in prison, that he appeared to be in shock and was in a very low mood. He noted that his English was poor, and that he would need to be assessed further the next day. The officer then took the man to the healthcare centre.

24. The senior nurse in charge of in-patients completed the Immediate Action Plan on the ACCT document and noted that he did not need any medical intervention

and knew about the Samaritans' phone and Listeners (prisoners trained by the Samaritans to support other prisoners in distress).

25. The nurse interviewed the man for an ACCT assessment. He told the nurse that he did not know why he was in prison, that he had no history of depression, and no history or current thoughts of suicide or self-harm. He said that he felt sad and anxious about being in prison, and had no family in the country. The nurse told the investigator that they communicated well and that he had understood her until she began to ask him questions about his alleged offence, when he began to say that he did not understand. The nurse thought it likely that he was avoiding a difficult topic, rather than not understanding. She decided not to use the telephone interpreting service as it was late in the day, she had no concerns that he was at imminent risk of harming himself and she did not want to risk upsetting him by pressing him on a subject he was obviously sensitive about. She wrote on the ACCT document that staff should check the man at least once an hour. She arranged an ACCT review for the next day and noted that court appearances were a potential trigger point for suicide and self-harm.

26. An operational support grade (OSG) and a nurse were on duty in the healthcare centre that night. At 8.20pm, the man pressed his cell call bell and the OSG found him crying. He said that he had broken his cup and the OSG gave him a replacement. He asked if he could share a cell with another prisoner, but the OSG explained that this was not possible in the healthcare centre. The OSG said that he spent a few minutes talking to the man to try to reassure him. He told him that if he wanted anything he could press his cell bell. The OSG said that, although the man did not have a strong grasp of English, he was confident that he had understood what he told him.

27. After this the man settled. The ACCT document shows that staff checked him once an hour through the night. The entries were all regularly on the hour, but the OSG and the nurse said that either or both of them checked him between these times at least once, and at irregular intervals. The OSG said that he would only note additional checks on the ACCT document, if there had been any concerns.

28. At 9,45am on 7 May, the man went to court and returned to Holme House at 11.41am. A nurse did not assess him in reception when he returned from court even though court appearances had been identified on his ACCT document as a potential trigger for suicide and self-harm. The nurse noted on his medical record that there was no change in his circumstances and did not assess him again.

29. At 2.30pm, a nurse chaired an ACCT case review with a nurse from the mental health team and an officer from the safer custody department. The note of the review said that the man had limited English but seemed to understand where he was. He denied having done anything wrong and was upset at being in prison. He said he did not have any history or thoughts of self-harm. The review assessed the man's risk of suicide and self-harm as low and agreed to reduce the minimum level of observations from once an hour to one each morning, afternoon, evening and once during the night. They did not use the telephone interpreting service but arranged to hold a further review the next day, using Language Line, and consider whether he should remain in the

healthcare centre. The nurse chairing noted on the ACCT caremap that the man had limited English. She asked the officer to arrange to use Language Line when required, and for the man to be given information in his own language. She noted that it was the man's first time in prison, so he needed to receive a full induction about the prison regime when he moved to a houseblock.

30. Although they now had to observe the man once at night under ACCT procedures, the OSG and the nurse said they still checked the man hourly during the night. At the end of her shift, the nurse noted on the man's medical record that there had been no cause for concern through the night.

31. The next morning, 11.15am on 8 May, a manager from the safer custody department chaired an ACCT review to assess whether the man could leave the healthcare centre. Two nurses and the equality officer also attended. The man said through the Language Line interpreter that he had no intention of harming himself, and had no mental health issues. He said that he understood the ACCT process, and was content to move to a houseblock. The only concern he raised was about his forthcoming court appearances. The review agreed that he should continue to be supported by ACCT procedures, but that he should move from the healthcare centre. The manager from the safer custody department updated the caremap with an action for houseblock staff to give the man a full prison induction when he arrived.

32. After the review, the foreign national co-ordinator spoke to the man using Language Line, and explained issues specific to foreign nationals, such as how to make international telephone calls, how to liaise with the immigration authorities, and whether he wanted the prison to contact the Eritrean authorities in the United Kingdom on his behalf. The foreign national co-ordinator gave him the relevant forms for these issues. The man said he understood and would take the forms away to consider. He said he had no other matters to raise. The foreign national co-ordinator explained how the man could contact him if he had any further questions, and the man said he understood.

33. That afternoon, a nurse noted on the man's medical record that she had not completed a full mental health initial assessment as she had been able to assess him during the ACCT review using Language Line. She noted that the man had said that he no current thoughts of suicide or self-harm and did not consider that he had any mental health problems. He said that he had never had contact with mental health services. The nurse found no evidence of psychotic symptoms.

34. The man moved from the healthcare centre to Houseblock Four, the prison's induction unit, at 3.40pm. As a young adult prisoner (aged below 21), he could not share a cell with someone older. Holme House will not allow another young adult to share a cell with someone charged with murder until a period of observation and assessment indicates that this would be appropriate. Staff therefore gave him a double cell to himself on the first landing (the ground floor).

35. An officer explained the houseblock rules and procedures to the man and told him about the support services available. The officer told the investigator that because of the man's limited grasp of English, he explained things in simple

terms. He knew he could have used Language Line, but said that he was confident that he understood the information he gave him.

36. At 5.30pm, an officer spoke to the man. He noted in the ACCT document that he did not appear to have any problems or concerns. There were no further entries until 6.00am on 9 May, when an officer noted that there had been no cause for concern overnight.

37. A note in the ACCT ongoing record at 8.30am (the signature is illegible) said that the man had refused to engage with the induction process. However, at 9.35am, an officer gave the man a basic induction about procedures on the houseblock. The mental health team discussed him during their meeting that day. The nurse said that she had not found any evidence of mental illness. Because the man was facing such a serious charge, the nurse added him to the standard waiting list to see a psychiatrist.

38. The man had a visit booked for 1.45pm with a family friend from London. A prison officer asked another prisoner from Houseblock Four to show the man to the visits hall. An officer noted on his ACCT document that there were no apparent issues during his time in the visits hall. When interviewed, he said that he had seen the man talking to his visitor, but he did not show any signs of distress.

39. The man's friend said that, as he was leaving the visiting area on his way out of the prison, he had told the prison officer escorting him that his friend had cuts and bruises on his arms and had clearly been in distress. He said that he had handed what he described as a ticket to the prison officer, who said that he would be able to identify the prisoner from that and would take some action.

40. After the visit, the prisoner walked back to the houseblock with the man. He said that the man did not seem upset and he did not see any change in his demeanour from earlier. When they got back, the manager from the safer custody team and the foreign national co-ordinator were visiting Houseblock Four and decided to go to see the man. He said he had no problems to raise with them. It was a Friday, and they said they would come back to see him again on Monday.

41. An officer spoke to the man at 6.00pm. He noted on the ACCT document that he said that he was okay and had no problems or concerns. The next entry was at 6.00am on Saturday 10 May, when an officer noted that the man had had a quiet night and that there had been no concerns.

42. Prisoners were unlocked at 11.30am on Saturday 10 May. CCTV footage shows that the man came out of his cell and played pool with other prisoners. After lunch, prisoners were unlocked again. The man came out of his cell just before 3.30pm. A fellow prisoner told the investigator that, although he did not speak much English, the man went upstairs and spoke to one or two other prisoners on the second landing and played pool. CCTV footage confirms this. After about half an hour, he went back up to the second landing and asked the prisoner if he would help him fill out some forms, including for meal choices and shop orders. They came down the stairs and collected the forms from the man's cell, and the prisoner helped him fill them in. Shortly after this, officers locked prisoners back in their cells.

43. At 6.30pm, an officer checked the man through the observation panel in his cell door. There were no apparent problems and he noted in the ACCT document that the man had come to the cell door and acknowledged him. At 7.38pm, the officer went to see another prisoner, but, because the man was being managed under ACCT, as he passed his cell he stopped and spoke to him briefly. When interviewed, he said that the man had said he was all right, then went and sat on his bed. He said that he gave him no cause for concern. At 8.38pm, an officer went to the man's door and spoke to him. He said that he had not noticed anything out of the ordinary that worried him about the man.

44. The cell bell monitor in the houseblock office was not working at the time. An officer had reported this, and told the investigator that he had made sure he looked at signals on the landings themselves, where cell bell alerts also registered. The electronic system still recorded any cell bells that were pressed and records show that he did not press his bell during the night. There were no entries in the houseblock observation book to indicate any other problems that night. The prisoners in the cell next to the man said that they did not hear anything from the man's cell during the night. Electronic records show that officers patrolled the houseblock during the night.

45. An officer started a roll check of the houseblock shortly after 6.00am on a Sunday in May, and reached the man's cell at 6.21am. He looked through the observation panel and saw him hanging from the top bunk bed by a ligature made from a bed sheet. During the night, prison staff do not carry cell keys but have a key in a sealed pouch for use in an emergency. The officer called a code blue emergency on his radio (indicating a life-threatening situation), broke the seal on his pouch and immediately went into the cell. The control room called an emergency ambulance, as soon as they received the code blue call.

46. Houseblock Four is also the prison's drug and alcohol treatment unit wing, and a nurse is always stationed there. The nurse heard the emergency call and went straight to the cell, taking the emergency grab bag from the treatment room. He arrived as the officer cut the ligature and laid the man on the cell floor. The nurse checked him for signs of life. Other staff, including the nurse on duty in healthcare arrived in response to the emergency call. The nurse told her that he thought that the man was dead. She checked the man for signs of life but could not find any. She noted small cuts to his left wrist and the inside of his left elbow and some small spots of blood on the cell floor. She was certain that the man was dead and had been for some time. The nurses therefore considered it was inappropriate to attempt to resuscitate him.

47. At 6.28am, the ambulance arrived at the prison and went to Houseblock Four. An ambulance service fast response vehicle arrived shortly after. The ambulance staff checked the man, and agreed that he had died.

### Informing the man's family

48. The man had not given the prison any contact details for his next of kin, and had said that all his family were in Africa. The prison asked the police to help and, at 3.45pm on 11 May, they said that they had traced his cousin in Birmingham. The prison's family liaison officers went to Birmingham that evening to inform his cousin that he had died. They continued to liaise with his

family over the coming days, and arranged a visit to the prison. His body was repatriated to Eritrea and his funeral was held there. The prison offered a contribution to the funeral and repatriation costs, in line with Prison Service guidance.

### Support for staff and prisoners

49. The deputy governor held a debrief at 8.15am on 11 May, attended by all staff who had been involved in the response to the emergency. They did not identify any issues about the handling of the emergency. The staff care team attended to offer support to anyone who wanted it.

50. Staff reviewed the cases of all prisoners being managed under ACCT procedures in case they had been affected by the man's death. Staff briefed Listeners and informed the local Samaritans.

### Post-mortem

51. The post-mortem report showed that the man died from cerebral anoxia (lack of oxygen to the brain) as a result of hanging.

52. The report showed a small cut on the man's left forearm. There were no signs of restraint or assault, and no natural disease was present. In addition to the cut to his left arm, there were needle marks at the left elbow and wrist. There was no further evidence of cuts and bruises to his arms which his visitor had said he had seen on 9 May.

## ISSUES

### Communication with prisoners who speak little or no English

53. The man was from Eritrea and English was not his first language. The prison files show that members of staff had different views about his level of understanding of English. One nurse noted that he could understand and converse. Another nurse said that she had no concerns that he did not understand her. Another nurse said that she was confident that he had understood their interaction, and only began to say he did not understand when faced with questions addressing difficult issues about his alleged offence.

54. Three officers all pointed out that, although the man's English was not good, (one of them said he spoke little English) they were confident that he understood what they told him. The staff were aware that they could use the Language Line telephone translation service, but did not think it necessary. When reviewing whether he should move from the healthcare centre, the manager from the safer custody department said that he used Language Line because they were having a more involved discussion. The foreign national co-ordinator also used Language Line when he gave the man a foreign national prisoner induction, but when he and the manager from safer custody visited the man the next day to check on his wellbeing, did not think it was necessary.

55. Prison Service Instruction (PSI) 64/2011 says:

    > 'All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and / or during the risk management process.'

    It also says:

    > 'Where prisoners do not speak English, ACCT assessments must be undertaken with the assistance or involvement of an interpreter, or appropriate translation service.'

    Although the man did not have a strong grasp of English, the members of staff we interviewed said they believed that he could understand basic information. An officer from the safer custody department had been asked to provide information for the man in his own language, if required, and the foreign national co-ordinator told him that he could ask him if he needed anything but the man did not ask for help. A fellow prisoner said that while the man's English was not good, they were able to make themselves understood to each other.

56. Holme House's Foreign National Prisoners' Policy says staff communicating with prisoners who do not speak fluent English must do so with regard for the prisoners' understanding, and use translation or interpreting services where appropriate. We have seen records which show that staff use interpreting services relatively frequently at Holme House. We also note that inspectors found this to have been the case during their inspection in 2013. In this case, staff seem to have considered the man's level of understanding, although it is not always clear how they reached the judgement that he could understand.

57. Records do not show that anyone asked the man if he wanted to use an interpreter which would have been the best way to have ensured that he received the level of support necessary to understand what was happening to him and to be able to communicate his own thoughts and feelings. We are also concerned that at the first ACCT case review on 7 May, and the assessment which preceded it, the two nurses did not use the telephone translation service, yet one of them asked for it to be used at a review the next day to discuss whether the man should move to a standard prison houseblock. On the caremap she noted that he had 'limited English.' We believe that this decision was not consistent and that if there was any doubt over the man's understanding, then the ACCT assessment and the review – which are designed to ensure the prisoner's safety - should have been conducted through an interpreter. The staff agreed that he could understand basic information, but we do not consider that that level of understanding was sufficient to deal with his complex situation and issues about risk. We make the following recommendation:

**The Governor should ensure that staff dealing with prisoners who are not fluent in English ask them if they need translation or interpreting services, and that interpreters are used in all ACCT assessments and reviews where there is doubt about the prisoner's level of English.**

**Clinical care**

58. New prisoners in Holme House charged with murder are usually allocated to the healthcare centre for at least the first night so they have additional support. The clinical reviewer considered that this demonstrated good care.

59. The man left the prison for a court appearance on the morning of 7 May. Staff said that the practice at Holme House is that if a prisoner returns from court with a change in their circumstances, such as being convicted or having their remand period extended, a nurse will assess them. A nurse noted on his medical record that there was no change in his circumstances, so he did not assess him further.

60. Prison Service Order (PSO) 3050 notes that appearances at court can have a significant impact on the health of the prisoner and states that prisons should have a protocol that screens prisoners passing through reception for any potential healthcare or suicide/self-harm issues. The man was already being managed under ACCT procedures, and "court appearances" were given as a potential trigger for suicide or self-harm on his ACCT document. Although the man had an ACCT review later that day, he should have been assessed in reception when he returned from court. We make the following recommendation

**The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health or suicide and self-harm issues after all court appearances.**

**Assessment of the man's risk of self-harm or suicide and ACCT**

61. When the man arrived at Holme House, he had a number of recognised factors that can raise a prisoner's risk of suicide and self-harm. Staff recognised this, and opened an ACCT. Reception staff completed the immediate action section of the form and a nurse held an assessment interview before he was taken to his cell. Although he was reluctant to discuss his alleged offence, the nurse was confident that he was not in imminent danger of harming himself. (As noted above she did not use an interpreter as we would have expected.)

62. The man's first ACCT review was multidisciplinary with healthcare staff present, including a mental health nurse (although no interpreter). The case manager completed the caremap, and noted that court appearances were a potential trigger point at which he could be more vulnerable. It seemed that he understood the process and the review assessed his risk of suicide and self-harm as low. The case manager set a further review for the next day, after a mental health assessment, and asked for Language Line to be available. Those present agreed that in the meantime the level of observations could be reduced from hourly to three during the day and one at night. The next day, an ACCT review, using interpretation services, maintained the same level of observations and concluded that he could safely move from the healthcare centre.

63. We are satisfied that reception staff appropriately identified the man's risk factors when he arrived and opened an ACCT. However, there is no evidence on the ACCT document or elsewhere that these factors were reconsidered at the ACCT reviews to help make an assessment about his level of risk. In a Learning Lessons Bulletin of July 2014, in which we looked at issues arising from the self-inflicted deaths of 18 to 24 year old prisoners, we reported that risk assessments often relied too heavily on a prisoner's presentation and their own assurances that they had no thoughts of harming themselves. The risk factors of the man's young age, being in prison for the first time, early days in custody, and his alleged offence, all remained unchanged. We are concerned that his level of risk was assessed as low, just the day after he arrived at the prison, and staff reduced the level of observations as a result. The staff knew very little about him or his circumstances and we consider that this decision was premature and did not fully take into account his outstanding risk factors.

64. Court appearances were noted as a possible trigger for the man being at heightened risk of harming himself on the ACCT document, and he was due to appear in court on 12 May. However, this date was not mentioned in the ACCT document and there is no evidence that staff considered whether he needed any additional support as his next court appearance approached.

65. When the man was monitored overnight in the healthcare unit when he arrived at Holme House, the level of observation was set at one per hour. The members of staff on duty told us that they actually checked him more frequently than this, but only recorded hourly checks as there were no apparent concerns at these other checks. We are satisfied that this was done, but it is unfortunate that they did not record this when making their hourly entries as the entries suggest they were done regularly and predictably on the hour.

66. Once the level of observations had been reduced to one check during the night, staff working on night shifts made entries on the ACCT document to show that they had checked on him at the beginning and end of their shifts. The officer

said that he would not normally check a prisoner on an ACCT during the night, unless he had information that suggested it was necessary or if he noticed anything unusual from the prisoner during the night, such as noise or a light on. The ACCT ongoing record does not contain any information between 6.00pm and 6.00am on the night of 9 May. On 10 May, CCTV footage shows an officer checking on the man at 7.38pm and a further officer at 8.38pm, but they did not note those on the ACCT document as there was nothing of concern to report. Nobody then saw the man until an officer found him at 6.21am. While only checking once during the night would have been unlikely to have saved the man, we do not consider that these timings suggest that staff checked him once during the night. Checks at the beginning of the shift amounted to an evening check and those at the end were in the morning.

67. Research by this office show that a quarter of prisoners who took their own lives did so during the night. Monitoring cannot guarantee a prisoner's safety if they are determined to take their own life, but we consider that leaving a prisoner alone and not monitored in a cell for more than nine hours is not an appropriate level of support for any prisoner thought to be at risk of suicide and self-harm,

68. Prison Service Instruction (PSI) 64/2011 requires governors to have procedures in place to manage and support those at risk of suicide and self-harm. Holme House does not have a specific safer custody or suicide and self-harm policy but works directly from PSI 64/2011. We have previously recommended that Holme House produce clear local guidance about managing and supporting prisoners at risk of suicide and self-harm. In response, the Prison Service told us that Holme House had introduced a system of issuing yearly reminders to staff about managing self-harm warnings and describing areas of risk. We consider that the findings of this investigation show that formal guidance covering issues such as assessing risk and trigger points would help staff to keep prisoners safe. We make the following recommendation:

**The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them, including ensuring that:**

- **Trigger points are considered in ACCT reviews;**
- **Risk factors are properly considered when assessing a prisoner's level of risk;**
- **All checks are recorded in the ongoing record;**
- **The level of observations is meaningful and appropriate to the level of the prisoner's risk.**

69. On 9 May, the man had a visitor, who said that he had been distressed and had cuts on his arms. He said that he when he left the visit hall he told a member of staff of his concerns. He said that he handed over what he described as a ticket, and the prison officer said that he would be able to identify the prisoner from that and would take some action.

70. There were four officers working in the visits hall that day. Our liaison officer at the prison spoke to them, but none of them recalled speaking to the man's visitor. CCTV footage of the visits hall does not show his visitor interacting with any prison officers. No entry was made on the man's ACCT document, and

there is no written record of such a conversation. We have therefore been unable to establish what happened.

71. An officer worked with the man on the wing and was also on duty in the visits hall that afternoon. He knew that the man was being managed under ACCT procedures and said in interview that he would have looked for danger signs, but he did not notice any cuts or bruises on his arms. The post-mortem report refers only to a small cut on his left forearm. A nurse said that when she responded to the emergency call she found small cuts to the man's left wrist. It is not possible to say what marks he had on his wrist or arm during the visit, but the post-mortem found only one cut on his left arm and needle marks to his left elbow and wrist.

**Provision of bed sheets**

72. The man's family asked why the prison did not give him anti-tear bed sheets if he was thought to be at risk of harming himself. Prisons can remove articles from prisoners if they think that they might use them to harm themselves. If the risk is thought to be serious enough they can put prisoners under constant observation and remove all items from a prisoner including clothing and bedding leaving them with alternative clothing and bedding designed to be difficult to tear. Prison Service instructions rightly say that this should be a measure of last resort.

73. Removing all potential means of a prisoner harming himself would only be justified in cases where there was a very high risk of suicide and self-harm which could not be managed in other ways. At the last review, staff had assessed the man's level of risk as low, and had reduced the level of observation. As he did not seem to be at imminent risk of suicide or self-harm, we consider that it was a reasonable decision not to remove his bed sheets at that time. Although we have concerns that the staff underestimated his risk, we do not consider that his risk factors were such that the use of anti-tear bedding and clothing would have been justified.

**Emergency response**

74. When the officer found the man hanging, he immediately called an emergency code on the radio, broke the seal on his emergency key pouch, and went into the cell to cut the ligature. A nurse arrived at the cell very quickly. Control room staff called an ambulance immediately they heard the code blue. Sadly, the man had been dead for some time, and staff took the decision not to attempt to resuscitate him.

75. We are satisfied that the staff responded quickly and took appropriate emergency medical equipment to the man's cell. We consider that the decision not to attempt to resuscitate him was appropriate in the circumstances.

**RECOMMENDATIONS**

1. The Governor should ensure that staff dealing with prisoners who are not fluent in English ask them if they need translation or interpreting services, and that interpreters are used in all ACCT reviews where there is doubt about the prisoner's level of English.

2. The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health or suicide and self-harm issues after all court appearances.

3. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them, including ensuring that:

   - Trigger points are considered in ACCT reviews;
   - Risk factors are properly considered when assessing a prisoner's level of risk;
   - All checks are recorded in the ongoing record;
   - The level of observations is meaningful and appropriate to the level of the prisoner's risk.

**ACTION PLAN: [man's name] at HMP Holme House on 11/05/2014**

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
|---|---|---|---|---|---|
| 1 | The Governor should ensure that staff dealing with prisoners who are not fluent in English ask them if they need translation or interpreting services, and that interpreters are used in all ACCT reviews where there is doubt about the Prisoner's level of English. | Accepted | A notice will be distributed to all staff at Holme House reminding them of the need to ensure Language Line is used if staff have any concerns over a prisoner's level of understanding of English.<br><br>Holme House Safer Custody Policy will include guidance on the use of language line in ACCT reviews.<br><br>Adhoc management checks to be put in place to give assurance of compliance. | 30th January 2015<br>Safer Custody | |
| 2 | The Governor and Head of Healthcare should ensure that prisoners are<br>assessed for potential health or suicide and self-harm issues after all court appearances | Accepted | A procedure will be put in place to ensure all prisoners returning from a court appearance are assessed for potential risk of suicide and self-harm.<br><br>Ad hoc management checks to be put in place to give assurance of compliance. | 30th January 2015<br>Safer Custody<br><br>Care UK | |
| 3 | The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them, including ensuring that:<br>Trigger points are considered in ACCT reviews;<br>Risk factors are properly considered when assessing a prisoner's level of risk;<br>All checks are recorded in the ongoing record;<br>The level of observations is meaningful and appropriate to the level of the prisoner's risk. | Accepted | A Holme House Safer Custody Policy will be produced in line with PSI 64/2011.<br><br>A system has been introduced whereby a Custodial Manager completes ACCT quality checks, in addition to the management checks completed daily by the Duty Governor. A system of quality control checks by Safer Custody staff is also to be trialled. | 30th January 2015<br>Safer Custody | |