Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Williams, a prisoner at HMP Leicester, on 16 September 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael Williams was found hanged in his cell at HMP Leicester on 15 September 2015. He was 43 years old. I offer my condolences to Mr Williams' family and friends.

Mr Williams had spent ten days at HMP Lincoln before being moved to Leicester on 3 September because he was anxious that he would be at risk from prisoners who had allegedly assaulted him at Lincoln a few months earlier. The investigation found that reception staff at both prisons did not assess Mr Williams' risk of suicide and self-harm appropriately when he arrived. He was subsequently managed under Prison Service suicide and self-harm prevention procedures at Leicester after he actively self-harmed but I am not satisfied that the procedures were used fully effectively to support Mr Williams and staff did not review his risk when there were clear signs it had increased.

The move to Leicester did little to assuage Mr Williams' anxieties and I do not consider that he received the mental health support he needed. I am particularly concerned that, on the night he died, prison staff waited almost an hour before going into his cell to check him after they had last received a response from him. This was despite the fact that he had made a clear statement that he intended to kill himself that night and he should have been checked at least four times an hour. Emergency response procedures were poor.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2016**

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Summary

Events

1. Mr Michael Williams was released from HMP Lincoln on 1 May 2015 but his licence was revoked that day when he failed to attend a meeting with his offender manager. He arrived back at Lincoln on 4 May. On 7 May, other prisoners assaulted him searching for drugs they believed he had smuggled internally. He was released on 29 May.

2. In August, Mr Williams' licence was revoked again and he returned to Lincoln on 24 August. When he arrived he said he felt depressed and paranoid and a nurse referred him for a mental health assessment. He was held in the segregation unit as staff suspected he had drugs hidden on him. He remained segregated as he said he felt at risk from other prisoners. On 27 August, a nurse assessed Mr Williams' mental health and referred him to the primary mental health team. Mr Williams said he had no thoughts of suicide or self-harm but was anxious and emotionally unstable.

3. On 3 September, Mr Williams was transferred to HMP Leicester. At an initial health screen, a nurse saw cuts on his arms and referred him to the mental health team and the GP. On 9 September, Mr Williams asked to see a manager, a member of the Independent Monitoring Board and someone from the mental health team. He cut his arms and an officer began Prison Service suicide and self-harm prevention procedures, known as ACCT. Initially, he was monitored hourly. Mr Williams said he was worried that he would be homeless when he was released on 18 September. He was anxious that a prisoner who had assaulted him at Lincoln was on his landing and he had no television in his cell.

4. On 11 September, staff at his first ACCT case review, assessed Mr Williams' risk of suicide and self-harm as low and asked staff to monitor him by having three conversations with him each day. On 12 September, Mr Williams was moved to another wing. Two days later, he cut his arm badly and was taken to hospital for treatment. He was referred urgently to the mental health team. On 15 September, Mr Williams said that he intended to kill himself that night. No one reviewed his risk but, later that evening, a manager decided to increase the frequency of observations to four an hour.

5. At 9.45pm on 15 September, an officer checked Mr Williams and found he had covered the observation panel in his door. He told the officer to go away. After that, the officer could not see or get a response from him. At 10.45pm, another officer dislodged a sheet which had been preventing them seeing into the cell and saw Mr Williams hanging from the window bars by a torn sheet. The officers cut the sheet, called an emergency medical code and began to try to resuscitate Mr Williams, who was not breathing. A nurse arrived, asked for an ambulance, and continued emergency treatment until paramedics arrived and took Mr Williams to hospital. Mr Williams was declared dead at the hospital at 12.10am. Mr Williams had left a note in his cell saying he had not got the support he needed. Toxicology tests found that Mr Williams had taken new psychoactive substances at some point before his death.

Findings

6. Mr Williams was particularly anxious about a previous alleged assault at Lincoln in May and had a number of other risk factors. We consider that reception staff at Lincoln and Leicester should have identified that Mr Williams was at risk of suicide and self-harm when he first arrived at the prisons. The operation of ACCT suicide and self-harm prevention procedures at Leicester was not in line with national instructions. In particular, staff did not hold case reviews after Mr Williams self-harming behaviour indicated increased risk, caremap actions were poor and did not effectively address his concerns, and observations were not always carried out at the specified intervals.

7. Mr Williams was referred to the mental health team on 3 September and 14 September, but no one from the team assessed Mr Williams before he died or considered whether his anxiety and paranoia might have been caused by drug induced paranoia. In that respect, his care was not equivalent to that he could have expected to receive in the community.

8. We are concerned that it took almost an hour to go into Mr Williams' cell on the night of 15 September, even though he had been assessed as at risk of suicide, had said he intended to kill himself that night, and should have been checked at least four times an hour. Control room staff did not call an ambulance immediately as they should have done when the emergency code was broadcast resulting in a delay of at least seven minutes.

Recommendations

- The Governors and Heads of Healthcare at Lincoln and Leicester should ensure that reception, first night staff and all others responsible for assessing risk of suicide and self-harm consider and record all the known risk factors of newly arrived prisoners and open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.

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

    - Completing first case reviews within 24 hours of an ACCT being opened.
    - Allocating and informing ACCT case managers.
    - Setting caremap actions, which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.
    - Holding an ACCT review whenever an event occurs that could mean that a prisoner is at increased risk.
    - Carrying out observations as directed and at unpredictable intervals.

- The Governor of Leicester should ensure that staff check the safety of prisoners at risk of suicide and self-harm by opening cells as soon as possible when prisoners at risk cannot be observed and do not respond at ACCT checks.

- The Head of Healthcare at Leicester should ensure that there is an effective single point of referral system for mental health assessments, that assessments

take place promptly, are appropriately prioritised, are documented in the clinical record and ongoing treatment is provided as required.

- The Governor of Leicester should ensure that all prison and healthcare staff are made aware of and understand their responsibilities during medical emergencies and in particular that:
    - Control room staff call an ambulance as soon as an emergency code is broadcast.
    - Staff bring appropriate emergency equipment immediately to the scene.
    - Healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.
    - There are no delays in calling, directing or discharging ambulances.

The Investigation Process

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

10. The investigator visited Leicester on 24 September 2015. She obtained copies of relevant extracts from Mr Williams' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison.

12. The investigator interviewed 18 members of staff and two prisoners at HMP Leicester in November. The clinical reviewer joined her for some of the interviews. She subsequently interviewed three members of staff and the chair of the Independent Management Board by telephone. She spoke to East Midlands Ambulance Service and Mr Williams' solicitor.

13. We informed HM Coroner for Leicestershire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Williams' father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked the following questions:

    - Was Mr Williams depressed?
    - Was Mr Williams being monitored due to his risk of suicide and self-harm?
    - Why had Mr Williams been transferred from Lincoln to Leicester?

15. Mr Williams' father received a copy of the initial report and indicated that he was satisfied with the findings.

16. The National Offender Management Service (NOMS) also received a copy of the report. They accepted all the recommendations.

Background Information

HMP Leicester

17. HMP Leicester is a local prison that holds 325 men. It primarily serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Leicestershire Partnership NHS Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

18. HM Inspectorate of Prisons inspected Leicester in October 2015. Inspectors found that the prison was unacceptably overcrowded and there was too little attention to prisoners' safety and vulnerability during their early days in prison. Too many prisoners felt unsafe and levels of violence and intimidation were high. Substance misuse services were good but drugs and alcohol were easily available and supply reduction arrangements were poor. Recorded levels of self-harm were more than five times the level found in other local prisons and inspectors were not confident that staff could manage prisoners' vulnerability adequately because of the high number of prisoners being managed under ACCT procedures. The quality of ACCT management was not consistently good.

Independent Monitoring Board

19. 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 most recently published annual report for the year to January 2015, the IMB said that a strong management team and resilient staff had led to improvements in discipline, violence reduction, healthcare services and prisoner induction. The IMB considered that mental health provision had also improved. Safer custody issues had a high profile and ACCT reviews were held as appropriate although there were some omissions in the ACCT documentation.

Previous deaths at HMP Leicester

20. Since June 2011, we have investigated the deaths of five prisoners at Leicester, including that of Mr Williams. Three were self-inflicted. We have previously made recommendations about risk assessment and ACCT procedures. We identified similar issues during this investigation.

Assessment, Care in Custody and Teamwork

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

22. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

23. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

24. NPS are an increasing problem across the prison estate. They are difficult to detect as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.

25. In July 2015, we published a Learning Lesson Bulletin about the link between the use of NPS and an increased risk of death, damage to physical and mental health, bullying, debt and possibly suicide and self-harm. The bulletin identified the need for better awareness among prison staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

Key Events

26. On 12 August 2014, Mr Michael Williams was released from HMP Lincoln on licence from a 32 months prison sentence for burglary. On 20 August, he was recalled to Lincoln after he reoffended and, on 16 February 2015, he was sentenced to 21 months in prison for robbery and blackmail. On 1 May 2015, he was released for a second time, but his licence was revoked the same day because he did not attend an appointment with his offender manager (probation officer). He was sent back to Lincoln on 4 May.

27. On 7 May, three prisoners assaulted Mr Williams as they thought he had drugs hidden on him. The prison began an investigation and referred the matter to the police but Mr Williams would not cooperate with either investigation. A note in his medical record after the assault indicated that he was upset and tearful but he did not want to be referred for mental health support. He was moved to the segregation unit for his safety, and stayed there until he was released on licence on 29 May.

28. On 13 August, Mr Williams' licence was revoked after he missed appointments with his offender manager and was charged with shoplifting. On 21 August, he was convicted of the shoplifting offence but did not attend court.

29. On 24 August days later, he was arrested and taken to Lincoln. When he arrived, a reception officer recorded that Mr Williams misused drugs and alcohol and had depression. He said he had last self-harmed four months earlier and the officer recorded that Mr Williams had said that he was likely to harm himself in prison.

30. At an initial health screen on 24 August, Mr Williams told a nurse he had a history of self-harm but had no current thoughts of suicide or self-harm. He said he felt depressed and paranoid and wanted a mental health assessment. He was worried about being back at Lincoln after he had been assaulted in May. He asked to see a GP as he had pain in his ear and his heels. The nurse arranged a mental health appointment for 27 August and noted he needed a GP appointment.

31. Staff suspected Mr Williams had drugs concealed internally and took Mr Williams to the segregation unit. The next day, Mr Williams told a nurse who was doing segregation unit rounds that he wanted to see a GP. She gave him some ibuprofen (a painkiller). Mr Williams did not have a scheduled secondary health screen on 26 August.

32. On 26 August, staff reviewed Mr Williams' segregation. No drugs had been found but Mr Williams asked to stay in the segregation unit for his own protection as he believed he would be at risk of attack from other prisoners, after the previous assault. He asked to transfer to HMP Humber and stayed in the segregation unit until a transfer could be arranged.

33. While he was in the segregation unit, Mr Williams made a formal complaint (apparently to the IMB) in which he said that he was becoming agitated as he had made it clear he was suffering mentally but the prison had ignored his applications for access to the library and to have a television. He said he had missed medical appointments as staff had not collected him to take them to them.

He said he was not paranoid but felt victimised as the prison had left him to suffer in silence.

34. On 27 August, a nurse assessed Mr Williams' mental health. Mr Williams said he had no thoughts of suicide or self-harm but was scared and anxious that he might be assaulted and felt emotionally unstable. He said he had struggled to cope, wanted support and to see someone from the mental health team. The nurse said he would refer him to the primary mental health team.

35. The next day, Mr Williams told a nurse that he was angry that no one from the healthcare team had seen him the previous day (although a nurse had). On 29 August, Mr Williams told a GP during segregation unit rounds that he had ear pain. She arranged an appointment for 1 September.

36. On 31 August, the Chair of the IMB went to see Mr Williams about his complaint. He gave the Chair a letter in which he said that no one had taken him to his healthcare appointments and he could not get to them himself from the segregation unit. The Chair advised him to ask healthcare staff to come to see him in the segregation unit. He said that Mr Williams would not be able to use the main prison library but could use the segregation unit library and that he should speak to officers about not having a television.

37. In an undated letter to his parents, Mr Williams said, at worst, he would be in prison until March 2016, which was probably for the best as this would mean he would not have to attend probation appointments after he was released (as he would not be on licence). He said that he was okay and enjoying some rest. Mr Williams did not make any telephone calls and had no visitors while he was in prison.

38. On 1 September, a GP examined Mr Williams' ears and prescribed fucidin (an anti-bacterial cream). He missed another secondary health screen later that day. No reason was recorded. Later that day, his offender supervisor gave Mr Williams his formal recall documents, which indicated his release date was 18 September. Mr Williams asked her to contact his offender manager in the community, as he was worried he would be homeless when he was released. There is no record that she did this.

39. On 2 September, a healthcare administrator noted that Mr Williams was on the waiting list for a primary mental health assessment. That evening, a nurse fitted him for transfer to Leicester the next day. The next morning she saw him in reception before he left and Mr Williams told her that he had self-harmed as a method of coping at Lincoln but had not told staff. The nurse noted he had cuts on his arm, which looked like they had been made a week earlier. Mr Williams said he had no current thoughts of suicide or self-harm.

40. On 3 September, Mr Williams was transferred to Leicester. At an initial health assessment, a nurse noted cuts on his arms which Mr Williams said were a week old. He said he had no current thoughts of suicide or self-harm, and was waiting for a mental health assessment. She told him that she would refer him to the mental health team and add him to the list to see a doctor. She told the investigator that Mr Williams should have seen a doctor within a few days but this did not happen.

41. The nurse said she had placed a mental health referral for Mr Williams in the team's tray that day. The Mental Health Team Manager, who is responsible for receiving and prioritising referrals, said she did not remember seeing a referral for Mr Williams. However, it appears that the mental health team received the referral as he was on their waiting list when a nurse checked subsequently on 9 September. That afternoon, Mr Williams told an officer that he had no issues at Leicester and was happy to live on a standard prison wing.

42. A substance misuse worker assessed Mr Williams, who said he had used new psychoactive substances shortly before being sent to prison and wanted support for his drug habit after he was released. He said he had no thoughts of suicide or self-harm. She said that they did not have time to address his substance misuse problems in prison but she would arrange an appointment in the community once he was released.

43. On 7 September, Mr Williams moved from the first night centre to the substance misuse unit. It is not clear whether this was linked to his previous substance misuse or if it was the only available cell. An officer told the investigator that he told Mr Williams that there were no televisions available, but Mr Williams did not seem upset about this. He said he had asked Mr Williams how he felt but he did not reply.

44. On 8 September, the substance misuse worker told Mr Williams that she had contacted the community substance misuse team and would arrange an appointment with them. She said she would visit him the next week to help plan his release.

45. At 2.15pm on 9 September, Mr Williams pressed his cell bell and asked an officer if he could see someone from the mental health team and a member of the IMB. The officer told Mr Williams that he was trying to arrange this for him. Mr Williams then cut his arm with a razor blade. The officer radioed for a nurse and began ACCT procedures. He noted that Mr Williams was concerned about his location and had asked to see a manager, the IMB and a mental health professional. A manager decided that staff should check Mr Williams at least hourly until his first ACCT case review.

46. Mr Williams refused to allow a nurse to treat his cut. He said he wanted to speak to someone from the offender management unit and was upset about waiting to see someone from the mental health team. He started hitting his head against the wall and asked the nurse to leave his cell. The nurse then spoke to someone from the mental health team, who said Mr Williams was already on their waiting list.

47. At 2.45pm, Mr Williams pressed his cell bell and said he had changed his mind and wanted treatment for his cuts. A mental health nurse treated the wounds. Mr Williams told her that he had cut himself because he had been assaulted in Lincoln and he could hear other prisoners (but he did not know who they were) talking about the assault. He said he had been transferred to Leicester for his own protection but was upset he had no television. Mr Williams said he felt better after cutting himself and self-harmed as a coping mechanism. The nurse talked to him about other ways to manage his tension.

48. The nurse also spoke to Mr Williams about getting help to cope with the trauma of the assault, but said this was long-term work, which they could not complete before his release. She told him to ask his community GP for a referral. She said Mr Williams seemed satisfied but said he still wanted to see a manager, a member of the IMB and someone from the mental health team.

49. A GP sutured one of the wounds on Mr Williams' arm, which was bleeding. The nurse said Mr Williams was calm and said he had no thoughts of suicide or further thought of harming himself. She told the investigator that, although she had not completed a full mental health assessment, she was satisfied that Mr Williams did not need to see a psychiatrist and was not mentally ill.

50. The next morning, 10 September, an officer assessed Mr Williams as part of ACCT procedures. He told her that he was angry and frustrated and was not being treated fairly. He said he had been happy living in the first night centre but had not had a shower since he had moved to the substance misuse unit because he believed the prisoners who had attacked him at Lincoln were on the same landing, as he could hear them talking about it. He said he did not know who they were. (The investigator established that none of the prisoners involved in the alleged assault at Lincoln were at Leicester.) Mr Williams said he was annoyed about not having a television and was worried about being homeless when he was released. She noted that being in the substance misuse unit and being released might be triggers for Mr Williams to self-harm. She offered him a radio but he did not want one. He said he did not feel suicidal but did not know whether he would self-harm again. She noted that he needed mental health support and said she would speak to someone in the offender management unit about his housing options when he was released and would ask about getting him transferred from the substance misuse unit.

51. At 3.00pm, a custodial manager noted on Mr Williams' ACCT record that he could not chair an ACCT case review that day as there were no mental health nurses available. He spoke to Mr Williams who seemed angry and frustrated. He gave Mr Williams a radio.

52. At 10.15am on 11 September, the custodial manager held Mr Williams' first ACCT case review with a substance misuse worker a mental health nurse. Mr Williams said he was upset about his location in the prison and had issues with other prisoners on the landing who had also come from Lincoln, but he could not identify them. Because of this, he said he did not want to use the gym, mix with other prisoners during association periods or go outside to the exercise yard.

53. The custodial manager said that he thought that Mr Williams' attitude changed during the review and that, by the end, he was positive and said he had no thoughts of suicide or self-harm. Mr Williams said he had cut his arm impulsively as he was frustrated at the time. The review assessed Mr Williams' risk of suicide and self-harm as low and decided that staff should monitor him by having and recording three conversations a day with him. He noted two actions on Mr Williams' ACCT caremap. The first was to increase the activities available to Mr Williams such as exercise, association and the gym. He marked this as complete as Mr Williams said he did not want to mix with other prisoners and was happy in his cell. The second action was for the substance misuse worker to

check that he had an appointment for substance misuse support in the community, which was also marked as complete. The substance misuse worker told the investigator that Mr Williams said he did not want support for substance misuse problems in prison.

54. After the review, the mental health nurse noted in Mr Williams' medical record that she had observed no signs of mental illness. During the review, Mr Williams did not say that he wanted a mental health assessment and she said she did not think that he needed one. She did not know that he had previously been referred to mental health services.

55. On the front of the ACCT document, a Supervising Officer (SO) was named as Mr Williams' ACCT case manager. He did not know this until the investigator interviewed him.

56. On 12 September, Mr Williams asked to speak to the custodial manager. He said that he was still unhappy in the substance misuse unit. The custodial manager arranged for him to move to a cell with a television on the main residential wing that day.

57. On the morning of 13 September, an officer noted that Mr Williams did not want to talk to him or another officer. He had been angry and abrupt and had shut his cell door when the officer tried to speak to him. At 2.30pm, Mr Williams rang his cell bell and asked if he could apply to be segregated from other prisoners for his own safety. The officer said he would investigate this for him.

58. At 5.30pm, the officer went back to see Mr Williams and said he needed to know why Mr Williams wanted to be segregated and who he wanted to be kept apart from. Although he had been moved, Mr Williams said he was still concerned about other prisoners in the substance misuse unit but would not say more. The officer told the investigator that Mr Williams was acting strangely, as if he did not know where he was. He said he ended their conversation because he did not want to antagonise Mr Williams further.

59. At 10.45am on 14 September, Mr Williams cut his arm with a razor blade and the custodial manager and an officer took him to hospital where he had 13 stitches. At the hospital, Mr Williams told the custodial manager that he felt better when he cut himself. A nurse saw him when he got back to the prison that afternoon and noted that the stitches should be removed in five days. There is no record that she assessed his risk of suicide or self-harm. When he got back to the wing he told officers that he was not happy at Leicester and could not guarantee that he would not cut himself again.

60. That day, a member of staff made an urgent mental health referral. (The referral was unsigned so we do not know who did this.) The referral said that Mr Williams had been under the care of the mental health team at Lincoln, as he was paranoid and anxious. He had self-harmed again, thought that he was in danger from other prisoners, appeared stressed and had spoken about being assaulted at Lincoln. He believed those prisoners were at Leicester and were threatening him. The referral noted that there was no evidence that the information was correct. On 15 September, the Mental Health Team Manager saw the referral and added Mr Williams to the mental health waiting list.

61. At 2.30pm on 15 September, Mr Williams went to an education class. He was the first prisoner to arrive and told an education worker that he did not know why he was there. He said his release date was in a few days but he had not received any help. He said he self-harmed, did not want to live anymore and was going to kill himself that night. She said that Mr Williams seemed frustrated and angry. He said he had been neglected at Lincoln, had not got any support at Leicester and wanted the prison to be investigated after his death. She recorded this information in his ACCT document and in his prison record, but said that Mr Williams seemed relaxed by the end of the session and was playing chess with another prisoner.

62. Around 4.30pm, a SO collected Mr Williams from the education class and the education worker told him what Mr Williams had said. On their way back to the wing, the SO asked Mr Williams how he was and he said, 'so, so'. The SO said he had told Mr Williams that he would ask another member of staff to talk to him as he had to supervise the evening meal. He told the investigator that he had forgotten to ask anyone and he finished his shift and went off duty shortly afterwards.

63. The Head of Safer Custody was duty governor that day and checked all the ACCT documents. At 5.00pm, he looked at Mr Williams' ACCT record and saw the education worker's entry. He was concerned that there had been no further entries since. He asked Officer A to speak to Mr Williams and let him or a custodial manager know what happened.

64. Officer A went to speak to Mr Williams, but he walked past her and did not want to speak to her. She asked another officer to speak to him but the officer said he had already tried. She then asked Officer B to speak to Mr Williams.

65. At 5.06pm, Officer B went to Mr Williams' cell and asked him if he was okay. He said that he was not, as there were prisoners at Leicester who had assaulted him before. She said he could apply to be segregated if he felt at risk from other prisoners but Mr Williams did not reply. He became tearful and told her that he had self-harmed the previous day but would not do it again. He then said, "You'll see. It will all come out." She told Officer A that Mr Williams was very low and they should speak to the custodial manager about him.

66. Officer A rang the custodial manager, who was with the Head of Safer Custody, and the custodial manager decided to increase Mr Williams' observations to four an hour. He said he would speak to him as soon as he could.

67. At 7.30pm, the custodial manager went to see Mr Williams who was agitated and dismissed his offer of help. Mr Williams said he had housing problems and was due to be released in three days. He said he would look into this for him but Mr Williams said he did not trust him to do this. He asked Mr Williams about his statement that he intended to kill himself that night but Mr Williams would not confirm or deny it. He told Mr Williams he could talk to staff during the night and should use his cell bell if he wanted to speak to any one. He scheduled Mr Williams' next ACCT case review for the next day when staff would be able to look into his housing situation.

68. At 8.20pm, Officer C came on duty for a night shift on Mr Williams' wing. The custodial manager told him that Mr Williams' risk of suicide and self-harm had increased and an officer told him that he needed to check him four times an hour. The officer did not look at the previous entries in Mr Williams' ACCT document and did not know that Mr Williams had threatened to kill himself that night. The custodial manager also told the custodial manager who was in charge of the prison that night about Mr Williams.

69. Officer C did not check Mr Williams four times an hour but checked him at 8.30pm, 9.00pm and 9.30pm. At the 9.30pm check, Mr Williams had covered the glass on the door observation panel with tissue. He removed it when the officer asked him and they spoke for about ten minutes. The officer said that Mr Williams was angry and pessimistic. He said he felt neglected and no one from the mental health team had assessed him. He said he would send information about this to his solicitors and did not want to talk further.

70. Officer C went to check Mr Williams again at 9.45pm and found that he had covered the observation panel with tissue again and would not remove it. Mr Williams, told him to go away. He then unlocked the door inundation point (a removable bung that allows a hose to be used to spray water into a cell if there is a fire) to observe him but Mr Williams had blocked this with tissue which he could not dislodge. He walked away but said he knew that Mr Williams was alive at the time, as he had spoken to him.

71. Officer C came back a few minutes later and dislodged the tissue from the inundation point but Mr Williams had also placed a bed sheet over it, which meant he could not see into the cell. Mr Williams did not respond when he spoke to him so, shortly before 10.00pm, he went to the wing office and told a custodial manager that he had last spoken to Mr Williams at 9.45pm. The custodial manager told him to look through Mr Williams' observation panel or inundation point to check him and that they would need to go into the cell if this was not possible. The custodial manager did not think the situation was urgent and went to the main gate for other duties. The officer went back to Mr Williams' cell but was unable to remove the sheet covering the inundation point and could not see Mr Williams who did not respond.

72. Another prisoner on Mr Williams' landing asked for the dedicated telephone used to call the Samaritans. An officer collected the telephone from another landing and two officers opened his cell and gave him the telephone at 10.30pm.

73. The two officers then went to check on Mr Williams, who still did not respond. Officer C put a broom handle through the inundation point and moved the sheet. Officer D then dislodged the sheet using some card. He looked through the inundation point and saw Mr Williams hanging from the window bars by a torn bed sheet. It was 10.45pm. Officer C unlocked the door and cut the sheet while Officer D supported Mr Williams' weight and they lowered him to the floor. Officer D could not find a pulse and began chest compressions to try to resuscitate him. At 10.46pm, Officer C radioed a code blue medical emergency (indicating situations such as when a prisoner is unconscious or not breathing). The officers said Mr Williams felt cold and looked pale but his body was not stiff.

74. The night manager was at the main prison gate when he heard the code blue and went to the healthcare centre to collect a nurse, who had no keys and was locked in the centre. The nurse said he had heard a radio call, asking for Oscar 1 (the radio sign for the night manager) and for someone from healthcare to go to Mr Williams' cell. He said he did not hear a code blue.

75. When the nurse arrived, the two officers were trying to resuscitate Mr Williams and he asked the night manager to call an ambulance. The night manager radioed the control room at 10.51pm and an officer called an ambulance. East Midlands Ambulance Service timed the call at 10.53pm. The nurse could not detect a pulse. He told the investigator that Mr Williams looked grey and felt cold but was not stiff. He went to get a defibrillator and an oxygen mask from two landings below. Officer D set up the defibrillator while the nurse put the oxygen mask on Mr Williams. Officer C left the cell. The defibrillator found no shockable heart rhythm and the nurse and officer continued cardiopulmonary resuscitation until paramedics arrived at 11.00pm and took over Mr Williams' care. The paramedics took Mr Williams to hospital but he did not recover. His death was recorded at 12.10am.

76. After Mr Williams' death, officers found a letter in the wing post box that he had written to his mother. He said that he had tried to get staff to listen but that he was being "played at every angle". He asked for an investigation, and for his mother to speak to his solicitors.

77. Staff also found a note in Mr Williams' cell. He said that he had asked for help but had received none and that he had been victimised. He said that he was on an ACCT but no one spoke to him. He said he hoped the IMB would investigate. Mr Williams had written on his cell wall, "I forgot about the statement left with solicitor for compensation reasons. I may be dead but at least you end up paying. Get on that regstar [sic]. Believe now."

78. Mr William's solicitor told the investigator that Mr Williams had told him on 8 June 2015 that he had been assaulted at Lincoln in May and was therefore worried about going back to Lincoln. He said he had named the prisoners who he alleged had assaulted him. Mr Williams had told him that a police officer had gone to see him after the assault but had not taken a formal complaint. The solicitor said he did not know what Mr Williams had meant by saying he had left a statement with his solicitor for 'compensation reasons' and he did not have any statement from him.

Contact with Mr Williams' family

79. When the prison contacted the police to inform them of Mr Williams' death, the police offered to tell Mr Williams' family. As there were few staff on duty at night, and Mr Williams' parents lived an hour away, the Governor, agreed. Later that night, the police said they had told Mr Williams' parents.

80. The next day, 16 September, the deputy governor rang the police to check they had told Mr Williams' parents that he had died and found they had not. The police had discovered his parents were on holiday in Devon and had referred the matter to the local police. She decided to call Mr Williams' parents to avoid them finding out from someone else. She offered her condolences and support.

(Usually we would expect someone from the Prison Service to inform families in person but we accept this was a difficult situation.) The prison's Head of Offender Management and a prison chaplain visited Mr Williams' parents on 18 September when they got back home. The prison contributed to Mr Williams' funeral costs in line with Prison Service instructions.

Support for prisoners and staff

81. After Mr Williams' death, the Head of Safer Custody spoke individually to the prison staff involved in the emergency response and offered his support and that of the staff care team. After Mr Williams was taken to hospital, the nurse had gone back to the healthcare centre and no one went to see him to offer support. (We have drawn this to the attention of the prison and the Head of Safer Custody has accepted that this was a regrettable oversight.)

82. The prison posted notices informing other prisoners of Mr Williams' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Williams' death.

Post-mortem report

83. A post-mortem examination established that Mr Williams died as a result of hanging. A toxicology report noted that Mr Williams had used synthetic cannabinoids sometime before his death but did not give any indication when. The report concluded that this did not directly cause Mr Williams' death but could have contributed to his mental health problems.

84. The post-mortem examination discovered a note in Mr Williams' stomach, wrapped in cling-film. The note said that he had been "stitched up since day one by staff 005/321 and just about everyone else. Investigations need to be made. Contact solicitor..." These staff numbers relate to a custodial manager and Officer C.

Findings

Identifying and managing risk

85. Although Mr Williams was subsequently identified as at risk of suicide and self-harm, we are concerned that reception staff and other staff at both Lincoln and Leicester did not appear to consider his risk factors when he first arrived at each prison and did not begin ACCT procedures.

86. Prison Service Instruction (PSI) 64/2011, which deals with safer custody, and PSI 07/2015 (Early Days In Custody), list a number of factors and potential triggers, which increase the risk of suicide and self-harm. Mr Williams had a number of risk factors when he arrived at Lincoln on 24 August 2015, including recall to prison, a history of depression, previous self-harm and drug use. He told a reception officer that he was 'likely to self-harm'.

87. There is no evidence that the reception officer asked him about his feelings when he said he was likely to harm himself or that he considered opening an ACCT. Although Mr Williams told the nurse that evening that he had no thoughts of suicide or self-harm, he said he was depressed and paranoid and very anxious about being at Lincoln because of the assault in May. The nurse noted that he had history of self-harm and had scars on his arms. There is no record that she took into account Mr Williams' risk factors or considered whether to open an ACCT. The mental health nurse who saw Mr Williams at Lincoln also missed an opportunity to identify his risk after he said he was anxious and felt unstable. The reception nurse who saw Mr Williams on the day he left for Leicester noted he had recent signs of self-harm, which he had not reported during his stay at Lincoln, but took no further action.

88. Mr Williams moved to Leicester on 3 September 2015. He was single, homeless, had been recalled to prison, and was very anxious about his safety from other prisoners. He said he had misused drugs in the community and recently self-harmed. These were all factors which increased his risk of suicide and self-harm. A nurse assessed him when he arrived at Leicester and she also saw Mr Williams' recent cut to his arm. He told her that cutting himself was his way of coping but that he had no current thoughts of suicide or self-harm. Despite his recent self-harm, there is no record that she considered whether an ACCT was necessary.

89. In our thematic report about risk factors in self-inflicted deaths published in April 2014, we noted that risk assessments too often relied on staff perceptions of the prisoner's behaviour and demeanour rather than on known risk factors. We reinforced these messages in a recent learning lessons bulletin, issued in February 2016, about early days and weeks in prison. We are concerned that there is little evidence that staff at Lincoln or Leicester appropriately considered Mr Williams' risk factors when he arrived at either prison. We make the following recommendation:

The Governors and Heads of Healthcare at Lincoln and Leicester should ensure that reception, first night staff and all others responsible for assessing risk of suicide and self-harm consider and record all the known

risk factors of newly arrived prisoners and open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.

Management of ACCT procedures

90. Mr Williams was managed under ACCT procedures at Leicester from 9 September until he died. The investigation identified some procedural failings in the operation of the ACCT process, which meant that Mr Williams did not always receive an appropriate level of support.

91. Mr Williams' first case review should have taken place within 24 hours of the ACCT being opened, ideally immediately after the ACCT assessment with the assessor present. PSI 64/2011 says that the review must not be delayed to ensure full attendance. However, the first case review was not held until two days later, without the assessor. A custodial manager said that he could not hold a case review within 24 hours as there was no one from the mental health team available. The mental health team manager told us that a nurse was available each weekday (which this was) for ACCT case reviews. A SO did not know that he had been appointed as the case manager.

92. PSI 64/2011 states that caremap actions should be detailed and time-bound, and aimed at reducing the risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress and cover issues such as cell sharing, time out of cell, access to regime activities and family contact. During the assessment interview, an officer had identified Mr Williams' concerns as being his housing on release, his mental health and his anxiety at his location in the prison, where he believed he was at risk of attack from other prisoners. It is clear that the assault at Lincoln, and his belief that the alleged perpetrators were now at Leicester, was a major concern for Mr Williams.

93. None of these issues were reflected in the caremap which instead identified attendance at activities, which Mr Williams did not want to do and arranging a substance misuse appointment in the community for after his release. There was nothing that would help reduce his risk in prison such a reviewing his location, arranging mental health support, helping with accommodation concerns of even arranging to get him a television, which he had said was a problem for him. A custodial manager moved him the next day when Mr Williams asked to see him, but this should have been identified at the case review.

94. In addition to planned case reviews, PSI 64/2011 says a case review should be held when there are additional concerns. We consider that when Mr Williams cut his arm severely on 14 September and needed hospital treatment there should have been a case review to review his level of risk. Without a case review after this serious self-harm, his risk remained assessed as low and the level of observations remained at just three conversations a day.

95. On 15 September, when Mr Williams said that he intended to kill himself that night, we consider there should have been a further case review to examine his level of risk and consider whether he needed extra support. A SO said that he had intended to ask a member of wing staff to speak to Mr Williams but forgot. He did not consider holding a case review. By chance, the Head of Safer Custody checked Mr Williams' ACCT document at 5.00pm that evening, which

led to the level of observations being increased. A custodial manager told us that there were no mental health staff available to carry out a case review but he had not checked. (The Head of the mental health team said a nurse was on duty until 8.30pm.)

96. Officer C should have observed Mr Williams four times per hour, but there were half hour gaps between the checks at 8.30pm, 9.00pm and 9.30pm. Between 8.30pm and 9.45pm when he last had a response from Mr Williams, there should have been a minimum of six observations. Yet, there were only four, at predictable intervals. The checks were not completed in line with the required frequency.

97. We are not satisfied that the prison managed ACCT procedures effectively to support Mr Williams. We make the following recommendation:

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

- **Completing first case reviews within 24 hours of an ACCT being opened.**
- **Allocating and informing ACCT case managers.**
- **Setting caremap actions, which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.**
- **Holding an ACCT review whenever an event occurs that could mean that a prisoner is at increased risk.**
- **Carrying out observations as directed and at unpredictable intervals.**

Response to blocked observation panel

98. We are concerned that after Officer C could not see Mr Williams at 9.45pm on 15 September, it took another hour before anyone went into the cell, even though he had stopped responding to him. Shortly before 10pm, the night manager told the officer that, if he could not see Mr Williams, they would need to unlock his cell. Although Mr Williams had threatened to kill himself that night, and was supposed to be checked four times an hour, the night manager and officer did not appear to recognise the urgency of the situation and it was 10.45pm when the two officers went into the cell.

99. Officer C said that he did not initially think the situation was urgent when he could not see Mr Williams but on reflection, realised he should have opened the door much sooner. He said he thought that three members of staff had to be present to open a cell at night. While that is the usual requirement, instructions about night procedures (PSI 24/2011) and about safer custody (PSI 64/2011) are clear that preservation of life takes precedence over the usual arrangements for opening cells when managing prisoners assessed as at risk of suicide and self-harm. At night, prison staff on wings do not carry standard keys but have a cell key in a sealed pouch for use in such an emergency. Where there appears to be immediate danger to life, prison staff can unlock cells by themselves without the authority of the night manager, subject to a personal risk assessment.

100. We recognise that it is difficult for staff in such situations to make immediate decisions but we would expect prison staff to go into a cell as soon as possible when they cannot observe or get a response from a prisoner who is being monitored as at risk of suicide. The purpose of such checks is to ensure the safety of the prisoner being monitored. Although Officer C should have been aware of the procedures for opening a cell in an emergency on his own, in these circumstances that should not have been necessary as there were other staff available on the wing at the time, including the night manager. As soon as the officer could not observe or get a response from Mr Williams, shortly after 9.45pm, staff should have opened his cell to check his safety. We make the following recommendation:

The Governor of Leicester should ensure that staff check the safety of prisoners at risk of suicide and self-harm by opening cells as soon as possible when prisoners at risk cannot be observed and do not respond at ACCT checks.

Mental health care

101. Mr Williams repeatedly asked for mental health support at Lincoln and Leicester. He had a mental health assessment at Lincoln on 27 August and was on the waiting list for an appointment with the primary mental healthcare team before he was transferred to Leicester on 3 September.

102. When Mr Williams moved to Leicester, he had to start the referral process for mental health support again. The nurse in reception at Leicester recorded that she had referred Mr Williams for a mental health assessment but there is no evidence that she considered whether he should be prioritised as he had already been waiting for an appointment at Lincoln, or because of his recent self-harm which she had identified when he arrived.

103. The Head of Healthcare said that with Mr Williams' history, he would most likely have been assessed as at medium risk of suicide and self-harm, and should have had a mental health assessment within three to four days. Yet, the ACCT review on 11 September 2015 assessed Mr Williams as at low risk. No one prioritised Mr Williams' mental health appointment, even though he had been assessed as at risk of suicide and self-harm on 9 September and self-harmed more seriously on 14 September. When a mental health nurse treated his wounds on 9 September, she did not consider he had a mental illness but spoke to him about ways of managing his tension and about getting long term help to cope with his apparent trauma of his assault. However, Mr Williams never received any formal mental health support at the prison before his death.

104. After Mr Williams had hospital treatment for a serious cut to his arm on 14 September, a nurse in reception did not assess his risk of suicide and self-harm as we would have expected to see. This was another missed opportunity to assess Mr Williams' risk properly. A member of staff completed an urgent mental health referral that day. However, when the Head of Healthcare saw the referral on 15 September, she added Mr Williams to the routine waiting list rather than prioritising the referral. (On 9 September, a nurse had already checked that Mr Williams was on the waiting list.)

105. The clinical reviewer noted that Mr Williams had shown some signs of auditory hallucinations and delusional beliefs in relation to the alleged assailants at Lincoln, none of whom were at Leicester. As Mr Williams had mentioned using new psychoactive substances before he came to prison (there is no evidence he used them in prison but we cannot discount this) the lack of formal assessment was a missed opportunity to consider whether his paranoia about the assault was attributable to drug use or other mental health problems.

106. In January 2016, we published a thematic report on prisoner mental health which identified several key lessons. These included ensuring that staff made a mental health referral if they had concerns about a prisoner; ensuring that mental health assessments, care and treatment took place promptly after any referral; and developing a clear and consistent process for staff to make referrals. We consider that these lessons need to be applied at Leicester. We consider it is particularly important that mental health assessments are prioritised for prisoners assessed as at risk of suicide and self-harm. The prison did not appear to be a clear, auditable referral system and referrals were not appropriately prioritised.

107. Although it appears that Mr Williams was referred for a mental health assessment the day he arrived at Leicester on 3 September, he never had a formal assessment or any ongoing mental health support, despite his subsequent acts of self-harm and possible drug-induced paranoia. The clinical reviewer considered that Mr Williams' mental health care was not equivalent to that he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare at Leicester should ensure that there is an effective single point of referral system for mental health assessments, that assessments are appropriately prioritised, take place promptly, are documented in the clinical record and ongoing treatment is provided as required.

Emergency response

108. Prison Service Instruction 3/2013 about medical emergency codes requires prisons to have a medical emergency response code protocol, which sets out how staff communicate the nature of a medical emergency, and that the control room should call an ambulance immediately when a code is used. The PSI says that It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required and that control room staff should not wait for a manager or a member of healthcare staff to confirm that one is required. Leicester's local protocol with the ambulance service is clear that staff should call an ambulance immediately and should not wait for additional information. However, it does not appear that the local practice is consistent with the local written policy.

109. Officer C radioed a code blue emergency at 10.46pm, immediately after he and Officer D had cut the ligature from which Mr Williams was hanging. Someone in the control room should then have called an ambulance straight away but the ambulance service did not receive a call until 10.53pm, seven minutes after the code blue was broadcast. This was after the nurse arrived and asked the night manager to call for one at around 10.51pm.

110. The officer working in the control room said he was waiting for the night manager to confirm that he should call the ambulance. He said that it was not the policy at Leicester to call an ambulance immediately an emergency code blue was called and he waited for a custodial manager or a member of healthcare staff to confirm this because staff often used emergency codes when an ambulance was not needed.

111. At night, healthcare staff do not have keys to enter the prison wings and they have to wait for a senior officer to meet them. The nurse appears to have waited approximately five minutes after the emergency code, which is too long in an emergency. We consider prisons should do everything they can to ensure that the preservation of life is placed over security arrangements and this practice caused an inherent delay. The nurse did not take emergency equipment with him and no one else had taken any in response to the code blue. This meant that shortly after he arrived, the nurse had to leave Mr Williams' cell to bring a defibrillator and oxygen mask, causing a further delay. We make the following recommendation:

The Governor of Leicester should ensure that all prison and healthcare staff are made aware of and understand their responsibilities during medical emergencies and in particular that:

- **Control room staff call an ambulance as soon as an emergency code is broadcast.**
- **Staff bring appropriate emergency equipment immediately to the scene.**
- **Healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.**
- **There are no delays in calling, directing or discharging ambulances.**

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