Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Russell, a prisoner at HMP High Down on 6 April 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 Matthew Russell hanged himself in his cell at HMP High Down on 5 April 2015, and died in hospital the following day. He was 33 years old. I offer my condolences to Mr Russell's family and friends.

Mr Russell had been appropriately identified as at risk of suicide and self-harm, but the investigation found some deficiencies in the operation of the procedures designed to support prisoners at risk, including poorly managed case reviews, observation levels which did not reflect risk and ineffective caremap actions. Allegations that Mr Russell was being bullied were not fully investigated. His mental health care was not well coordinated. I also consider that it took too long to inform Mr Russell's family after he was taken to hospital in a serious condition.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2015**

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Summary

Events

1. On 5 December 2014, Mr Matthew Russell was convicted of sexual offences against children and remanded to HMP High Down. On 23 January 2015, he was sentenced to 16 years in prison. Mr Russell had a history of mental health problems and depression, and had self-harmed for many years by banging his head against walls, cutting himself and taking overdoses. He had recently been treated as an inpatient in a psychiatric hospital.

2. From 5 to 14 December, staff monitored Mr Russell under suicide and self-harm prevention procedures (known as ACCT). Mr Russell said that he was innocent and planned to appeal his conviction. He was often anxious and stressed about not being able to speak to his partner. The prison doctor prescribed antidepressants and referred him to the prison's mental health in-reach team for support. On 8 January 2015, the mental health in-reach team, which deals with more severe cases of mental illness, discharged him from their care, and thought he would be more appropriately cared for by the prison's primary mental health team.

3. On 17 February, Mr Russell self-harmed by banging his head against his cell door. Prison staff began ACCT procedures and referred him to the mental health in-reach team again. A mental health nurse assessed Mr Russell and arranged to monitor him for support. The nurse saw Mr Russell frequently over the following weeks. After a meeting with him on 2 March, the nurse referred him to the prison's psychiatrist, but he did not attend the appointment.

4. Mr Russell self-harmed many times at High Down and prison staff often found him with, or tying ligatures. A week before he died, Mr Russell said that he was having problems with other prisoners and agreed to move cell. A few days later, Mr Russell said that another prisoner was bullying him. The other prisoner was moved from the houseblock after he attacked a member of staff. Staff thought that this had resolved the bullying issue and did not investigate this further.

5. At 7.14pm on 5 April, an officer found Mr Russell had hanged himself in his cell. Staff attempted to resuscitate him. Paramedics stabilised Mr Russell and transferred him to hospital. Sadly, he did not regain consciousness. The next morning, 6 April, doctors removed life support and he died shortly after.

Findings

6. We found that there were failings in the way that Mr Russell was managed under the ACCT process. Case reviews were not multidisciplinary and were not held when there signs of an escalation in his risk. The frequency of observations did not reflect Mr Russell's perceived risk and checks were at predictable intervals. ACCT caremaps did little to address the causes of Mr Russell's distress and reduce his risk. Mr Russell's mental healthcare was not well coordinated and there was a lack of effective care planning.

7. Staff did not properly investigate when Mr Russell said he being bullied to ensure he was properly supported.

8. The prison did not inform Mr Russell's family immediately when he was taken to hospital in a critical condition.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
    i. Case reviews should be multidisciplinary, attended by all relevant people involved in a prisoner's care and ensure continuity of case management. A member of healthcare staff should attend all first ACCT case reviews.
    ii. Reviews should assess the level of risk taking into account all risk factors including the impact of issues such as bullying. New reviews should be held when there is evidence of significant change in risk such as further plans or acts of self-harm.
    iii. Levels of observations should reflect the risk, should be adjusted when risk changes. Staff should carry out and record all observations as required.
    iv. Case managers should set caremap actions which are specific and meaningful, identify who is responsible for them and should review progress against caremaps at each review.

- The Governor should ensure that there are appropriate violence reduction procedures, including to protect prisoners in the vulnerable prisoners unit at risk from others in the unit, which are used actively, promptly and effectively to challenge prisoners suspected of bullying behaviour and to support their victims.

- The Head of Healthcare should ensure that prisoners with complex mental health problems, under the care of the mental health in-reach team, have structured and coordinated care plans, which are shared with all relevant staff and that their management is discussed at multidisciplinary team meetings.

- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners responded.

10. The investigator visited High Down on 14 April 2015 and obtained copies of relevant extracts from Mr Russell's prison and medical records.

11. The investigator interviewed 19 members of staff and four prisoners at High Down in May and June.

12. NHS England commissioned a clinical reviewer to review Mr Russell's clinical care at the prison. The clinical reviewer and the investigator interviewed some staff jointly.

13. We informed HM Coroner for Surrey of the investigation. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Russell's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Russell's mother asked if her son was being monitored as a risk of suicide and self-harm at the time of his death. She asked what the prison had done when a friend had raised concerns about him, when staff had last checked him and why it had taken so long for the prison to inform her, after he was taken to hospital.

15. Mr Russell's mother was concerned about the care Mr Russell received for his mental ill health and said that Mr Russell had complained that healthcare staff kept changing his medication and that he felt unsettled and not himself. Mr Russell's family received a copy of the draft report. They did not make any comments.

Background Information

HM Prison

16. HMP High Down is a local prison near Sutton, in Surrey, which holds up to 1,100 men. Virgincare provides health services at the prison. At the time of Mr Russell's death, Surrey & Borders NHS Foundation Trust provided mental health services. Since 1 May 2015, Central North-West London NHS Foundation Trust has provided these services.

HM Inspectorate of Prisons

17. The most recent inspection of High Down was in January 2015. Inspectors found that there was adequate strategic oversight of violence reduction but there was no formal support for victims of violence or bullying. Inspectors recommended that the prison should have a system to support victims.

18. Inspectors found the quality of ACCT procedures was variable, with inconsistent case reviews, incomplete caremaps and levels of observations, which were insufficiently frequent and carried out at predictable intervals. Inspectors recommended improvements in the quality and consistency of ACCT procedures and in the support staff gave prisoners in crisis.

19. Inspectors reported that health services were good overall, but staff shortages meant too many healthcare appointments were cancelled. Secondary mental health services were good but primary mental health services, although improving, were inadequate.

Independent Monitoring Board

20. 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 2014 annual report, the IMB was concerned about the quality of ACCT procedures and the implementation of anti-social behaviour procedures, but reported that staff were receiving further training in both areas.

21. The IMB considered that health care provision at High Down compared well with other prisons and that more prisoners were able to attend external health appointments and more were receiving psychiatric interventions.

Previous deaths at HMP High Down

22. Mr Russell's death was the first self-inflicted death at High Down since 2008.

Assessment, Care in Custody and Teamwork

23. 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.

24. 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 multidisciplinary 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.

25. 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.

Key Events

26. Mr Matthew Russell had served a number of community sentences since 2004, but had never been in prison before. He had a history of mental health problems and had twice been detained under the Mental Health Act, 1983. On 9 September 2013, police found him on top of a building, considering suicide, because he had been accused of sexual offences committed some years earlier. The police took him to a psychiatric hospital for assessment. Doctors diagnosed him with a mixed personality disorder and discharged him on 23 September. On 30 September, Mr Russell was remanded to HMP Doncaster and was monitored under ACCT procedures while he was there. On 8 October, he was released on bail.

HMP High Down

27. On 5 December 2014, Mr Russell was convicted of sexual offences against children. He told court staff that he felt suicidal and had harmed himself in the last six months. He cut his arm with a hair clip and court custody officers completed a suicide and self-harm warning form to alert the prison to his risk. That afternoon Mr Russell was sent to HMP High Down to await sentencing.

28. At an initial health screen, Mr Russell told a healthcare assistant that he had attention deficit hyperactivity disorder (ADHD), autism, and had been diagnosed with mixed personality disorder. He said he had been prescribed fluoxetine (an antidepressant), but was not taking it at the time. The healthcare assistant recorded that Mr Russell had a history of anxiety and self-harm, which included banging his head against walls to the point of unconsciousness. He said he had no current thoughts of suicide or self-harm, but she began ACCT procedures because of his risk. She referred Mr Russell to the prison's mental health in-reach team and for a learning disability assessment, as Mr Russell said that he had problems reading and writing. (Healthcare staff made appropriate efforts to get information about Mr Russell's previous medical history. The psychiatric hospital had information about his time there, but one of his last two GP surgeries no longer existed and Mr Russell had not attended the other since he had registered.)

29. Due to the nature of his offences, Mr Russell was allocated to A Spur on Houseblock Six, the prison's vulnerable prisoners unit. On 6 December, he told the officer who assessed him as part of ACCT procedures that he self-harmed when he felt stressed. He said that he did and did not want to be alive, that he was innocent of the offences and that, if he were to kill himself, it would be by inflicting a head injury. The officer noted that trigger times for Mr Russell to self-harm might be his daughter's birthday on 13 December, Christmas and 29 January, when he was due to be sentenced.

30. Later on 6 December, a member of staff held Mr Russell's first ACCT review with an officer. Contrary to Prison Service national instructions, no member of healthcare staff attended. Mr Russell said he had thoughts of self-harm, but did not want to kill himself. He said he was frustrated about not having contact with his family because of public protection restrictions. He said he tended to bottle up his emotions and found it difficult to talk. The review assessed Mr Russell as

at low risk of suicide or self-harm and decided that staff should check him once during the morning, afternoon and evening and three times during the night. The member of staff wrote in Mr Russell's ACCT caremap (which should set out actions identified to help reduce risk) that Mr Russell found it hard to talk about his problems. The action to address this was that Mr Russell should remain in a shared cell with his current cellmate, who he said he got on well with.

31. On 8 December, a nurse from the prison's mental health in-reach team assessed Mr Russell and noted that he was low in mood but said he had no current thoughts self-harm. Mr Russell said that he tended to harm himself when he was in a "hyper state", but not when he felt low. Mr Russell told the nurse he had not had any fluoxetine since he had arrived at the prison. He told the nurse that he had been taking fluoxetine for two years.

32. On 9 December, a nurse noted in Mr Russell's medical record that he had had no contact with his community GP since registering. The nurse spoke to Mr Russell's sister, who said her brother had been diagnosed with ADHD when he was 12. She said he had not been prescribed any medication for some years before he was sent to prison. He had previously been prescribed antidepressants but he had not taken them consistently. She said that Mr Russell had a tendency to make up stories about his life. The nurse made an appointment for Mr Russell to see a GP and noted that he might need to be referred to a psychiatrist.

33. On 10 December, a prison GP reviewed Mr Russell who said that he had recently been diagnosed with bi-polar affective disorder, and was about to change his medication. The doctor noted that Mr Russell had a history of self-harm by head banging and cutting. He had rapid mood swings and had previously been prescribed antidepressants. The doctor carried out the PHQ9 risk assessment, which assesses levels of depression from zero (no depression) to 27 (severe depression). Mr Russell scored 26, which indicated severe depression. The doctor prescribed a two-week course of fluoxetine. (Mr Russell continued to be prescribed fluoxetine until his death. A doctor did not review the prescription again.)

34. Later that day, a nurse assessed Mr Russell's learning needs. She noted that Mr Russell had some difficulty with reading and writing, but scored above the threshold for a full learning disability assessment. A learning disabilities nurse discussed Mr Russell with two nurses and agreed that there was no need for his input.

35. Staff entries in Mr Russell's ACCT document noted that Mr Russell seemed settled and reported no concerns. On 14 December, a supervising officer held a second ACCT case review with an officer. Again, no member of healthcare staff or from any other discipline attended. At the review, Mr Russell said that his self-harm was part of who he was and his way of coping. He said that he did not self-harm to kill himself and did not feel supported by the ACCT process. The supervising officer recorded that Mr Russell was at low risk of suicide and self-harm and closed the ACCT.

36. On 29 December, an officer who held an ACCT post-closure review noted that Mr Russell still had some mental health problems but had not self-harmed since

the ACCT was closed. Mr Russell said that he was in contact with his partner. He was still waiting to be allocated work and education places but used the gym when he could.

37. On 8 January, a mental health nurse with the in-reach team noted that Mr Russell's community medical records did not support a diagnosis of severe mental illness and that the prison doctors were managing his depression. He considered that the primary mental health team could manage Mr Russell's depression and discharged Mr Russell from the mental health in-reach team's caseload. There is no evidence of a formal referral or handover to the primary mental health team.

38. On 23 January, Mr Russell was sentenced to 16 years imprisonment and quickly applied to appeal against his conviction. On 27 January, he started a job in a prison workshop, but a week later began working as a wing painter instead. On 5 February, his partner visited him.

39. On 10 February, Mr Russell saw a nurse in the prison workshop and told him he had ADHD, autism, dyslexia and dyspraxia. He said that his fluoxetine was not working and that he had not received all his medications. The nurse told Mr Russell he would get back to him. He wrote in the medical record that he checked and found no record that Mr Russell had been diagnosed with autism, or that anyone had prescribed any medication, other than fluoxetine. He did not ask anyone to review him and did not report back to Mr Russell.

40. On 17 February, at 6.00pm, Mr Russell told two officers that he had banged his head against his cell door because he felt stressed. A nurse treated a cut and noted a lump on his head. He did not think that he needed to refer Mr Russell to the mental health team.

41. An officer opened an ACCT and noted that Mr Russell was worried about his partner. The officer noted that they had found 72 paracetamol tablets in Mr Russell's cell (he was allowed to keep up to 32 tablets in his cell). The nurse removed them. Night staff checked Mr Russell hourly through the night.

42. The officer told the investigator that Mr Russell came across as a troubled person who could not accept his imprisonment. He said Mr Russell was difficult to get to know and did not mix well with other prisoners. The officer said he knew Mr Russell missed his partner and, because he did not have much money, found it difficult to keep in contact with her by telephone. The officer said that staff had tried to call Mr Russell's partner on his behalf a couple of times. He said that Mr Russell also stressed about having enough money to buy tobacco.

43. At 11.10am on 18 February, a supervising officer spoke to Mr Russell's partner. The supervising officer told her Mr Russell was worried about her and wanted to know if she was okay. She had booked a visit for 5 March and the supervising officer gave her information about how she might be able to get help with the costs through the assisted visits scheme.

44. At 11.50am, an officer assessed Mr Russell as part of the ACCT procedures and noted that he was worried about his partner, frustrated at not being able to express his emotions, was anxious and unable to cry. He said he had banged

his head against the wall to relieve stress and had self-harmed in this way for 20 years. Mr Russell said he had nothing to live for since his children had been taken away from him, but that working and being out of his cell helped relieve stress. Hearing from his partner made him happy.

45. At 2.50pm, a supervising officer and officer held the first ACCT case review. As previously, there was no member of healthcare staff present. The officer had briefed the senior officer about her assessment of Mr Russell. The supervising officer noted that Mr Russell was calm but fidgety. He said he was concerned that his appeal might take two years. The supervising officer told him she had spoken to his partner. She noted that Mr Russell was now working in the textiles workshop, but became anxious when he was locked in his cell. She assessed Mr Russell's risk of suicide as low and instructed staff to record one quality conversation with Mr Russell in the morning and afternoon and to check him five times during the night. The supervising officer wrote as caremap actions that he should buy more telephone credit to speak to his partner, be referred to the mental health team, and his partner should be told about assisted visits (which she had already done). The supervising officer referred Mr Russell to the mental health in-reach team that day.

46. On 19 February, an officer wrote that Mr Russell was a lot happier now he had bought more phone credit and tobacco. He was chatting with other prisoners and making friends.

47. At 7.10pm, an officer noted that Mr Russell had accidently banged his head on the wall, but was otherwise okay. (The officer told the investigator that he knew Mr Russell sometimes banged his head to self-harm, but said Mr Russell had told him it was an accident and he had accepted this.) Mr Russell told a nurse, who treated a cut to his head, that he had deliberately self-harmed two days earlier by banging his head in the same place.

48. At around 12.25am on 23 February, an officer noted that Mr Russell was sleeping on his cell floor. At 2.45am, the officer checked again but Mr Russell did not respond. The officer called for assistance and a custodial manager attended with a nurse. The staff went into the cell and cut a loose ligature from around Mr Russell's neck. He did not need any medical treatment. Mr Russell had written a note to his partner, saying he wanted to kill himself. The custodial manager increased Mr Russell's observations to every 30 minutes, with the intention that staff would be able to review him properly in the morning.

49. At 11.40am, a supervising officer and an officer held an ACCT review, with no healthcare staff or other discipline represented. Mr Russell said he could not remember why he had tied a ligature. The supervising officer noted that Mr Russell felt more positive, and was waiting for the mental health team to assess him. The review assessed Mr Russell as at a raised risk of suicide and self-harm, but reduced the level of observations to one quality conversation in the morning and afternoon and five observations during the night. The supervising officer recorded that he had reviewed the caremap, but he did not add any new actions. He scheduled the next ACCT review for 2 March.

50. On 24 February, officers noted that Mr Russell was now working as a wing cleaner, and that he seemed to be in a good mood. The next day, Mr Russell applied to the chaplaincy to marry his partner.

51. On 26 February, a mental health nurse noted that a supervising officer had referred Mr Russell to the mental health in-reach team on 18 February. The nurse arranged for someone from the in-reach team to review Mr Russell the next day.

52. At 5.50pm on 26 February, an officer found a strip of sheet tied to the upper door hinge of Mr Russell's cell and asked Mr Russell about it. Mr Russell said he had tied it because he was confused, fed up and frustrated. He did not know where to turn and was upset about his lack of contact with his family. The supervising officer went to speak to Mr Russell. When the supervising officer and officer left Mr Russell, they recorded that he seemed much calmer.

53. At 8.20am on 27 February, an officer was unable to open Mr Russell's cell door as he was lying on the floor in front of it. She saw a television aerial cable next to him and Mr Russell said he had put it around his neck. Mr Russell agreed to move away from the door and let the officer in. She removed the cable from the cell.

54. That morning, a nurse from the prison's mental health in-reach team assessed Mr Russell. He told the nurse his family history of mental illness. He said that he self-harmed every day by scratching, making ligatures and by banging his head against his cell door. Mr Russell said he wanted to cry but could not, and slept for only two or three hours a night. He said he was looking forward to his partner, mother and sister visiting on 5 March. The nurse recorded that the mental health team would review and monitor Mr Russell to offer him support.

55. At 8.30pm, Mr Russell deliberately banged his head, which caused further bleeding. A nurse checked him, and an officer noted that he was okay and in good spirits. The officer recorded no further concerns that evening, but noted that Mr Russell was walking around in his cell in the early hours.

56. On 2 March, Mr Russell told a nurse that he had had a good weekend, but was still finding it difficult to sleep. He told the nurse that this led him to bang his head out of frustration. The nurse noted that Mr Russell was relaxed and bright in mood and made him an appointment with the prison psychiatrist for 28 March.

57. A supervising officer chaired Mr Russell's third ACCT review at 4.00pm, with an officer. The supervising officer wrote that Mr Russell seemed a lot better. Mr Russell said that he used an elastic band on his wrist as a distraction from thoughts of self-harm, and that these thoughts had reduced. The supervising officer closed the ACCT.

58. On 5 March, Mr Russell's family visited, but his partner did not. A nurse from the prison's mental health in-reach team saw him at 2.30pm, and noted that staff had closed the ACCT. Mr Russell said he was disappointed that his partner had not visited. He said he was innocent and had been punching the cell window in frustration. The nurse noted bruises on his knuckles. Mr Russell said that an officer had told him to wrap a mattress around his chair to punch so he would not

hurt himself. The nurse arranged for Mr Russell to be prescribed zopiclone for two nights, to help him sleep. At 6.00pm, the supervising officer re-opened Mr Russell's ACCT. An officer checked him hourly through the night and recorded no concerns.

59. On 6 March, Mr Russell did not go to work. He told an officer that he felt "shit" and asked to speak to the supervising officer. At 2.30pm, the supervising officer and an officer held an ACCT case review. The supervising officer noted that he had re-opened the ACCT because Mr Russell had been agitated over the last couple of days about the lack of contact with his partner and had used all his phone credit by leaving messages on her voicemail. Mr Russell said that killing himself was the only way out. The review assessed Mr Russell as at raised risk of suicide and self-harm. The supervising officer did not make any new entries in the caremap. He instructed staff to record one conversation with Mr Russell in the morning, afternoon and evening and to check him four times during the night.

60. At 5.15pm, a prison chaplain visited Mr Russell and noted in the ACCT record that Mr Russell was stressed because he did not have enough money for telephone credit to call his partner. The chaplain suggested Mr Russell write to his partner and said that they would pray together the following day.

61. Later that afternoon, Mr Russell said he was feeling stressed but did not want to speak to a Listener (a prisoner trained by the Samaritans to support other prisoners). At 7.10pm, an officer found him sitting close to his cell door with toilet paper and torn sheets wrapped around his head. Mr Russell said he was going to set himself on fire. The officer talked to Mr Russell until he seemed calmer, and told him to ring his cell bell if he needed help. At 8.37pm, the night patrol officer noted that Mr Russell was sitting on a chair close to his cell door with a sheet over his head. Mr Russell told the night patrol officer he did not want anyone to see his face.

62. On 7 March, Mr Russell went to the prison chapel and prayed with the chaplain. At 12.30pm, an officer wrote in the ACCT that she had challenged him about the state of his cell and his deteriorating behaviour (although it is not clear what she was referring to). She noted that Mr Russell then cleaned his cell and changed his clothes. At 5.35pm, she noted that Mr Russell had made a tent out of a sheet and felt low because he had not been able to make a phone call. The next day, Mr Russell went to the chapel, and afterwards, told the officer he was feeling much better. She noted that he was laughing and mixing well with other prisoners.

63. On 9 March, Mr Russell showed a nurse from the prison's mental health in-reach team scratches on his arms, which he said he had made two days earlier. He said he had no current thoughts of self-harm but was not sleeping well. Mr Russell had not been going to work for the past few days and the nurse encouraged him to go back to his job.

64. On 10 March, a nurse from the prison's mental health in-reach team saw Mr Russell in the prison workshop, where he now worked and noted that Mr Russell's forehead was bruised because he had head butted the cell door. Mr Russell said he was oblivious to pain when was actually banging his head, but it

hurt now. The nurse told Mr Russell to see the houseblock nurse and noted that he should have a mental health assessment.

65. That day, a supervising officer asked another prison chaplain to see Mr Russell. Mr Russell told the chaplain that he was concerned about his partner and the chaplain spoke to Mr Russell's partner on his behalf.

66. A supervising officer and an officer held Mr Russell's fifth ACCT case review, that afternoon. Mr Russell said he was okay but had self-harmed over the last week, because he had had difficulty contacting his partner. Mr Russell said his partner only had a mobile phone and lived in an area with poor reception, and he was not always able to get through to speak to her. This meant that he had used all his phone credit. He said that the chaplaincy team had helped him contact her. The supervising officer noted that Mr Russell would be able to buy more phone credit in two days. The review assessed Mr Russell as at low risk of suicide or self-harm. The supervising officer set the level of observations required as one recorded entry in the ACCT document about Mr Russell each shift and that staff should check him four times during the night.

67. On 12 March, an officer heard a tapping sound from Mr Russell's cell. When she went to see what it was, Mr Russell said that a knife was stuck between the door and the doorframe. The officer opened the door and removed a knife, toothbrush and comb with a thin strip of sheet attached. Mr Russell left the cell and spoke to Listeners. The officer told the investigator that she did not consider that Mr Russell might have been using the items to secure a ligature. When interviewed, she did not recall whether she had reported the incident but there is no record that she did.

68. No one noted any concerns abut Mr Russell over the following days. Workshop staff noted that Mr Russell had worked well.

69. On 14 March, Mr Russell seemed stressed. An officer tried to contact the mental health team, but got no response when she phoned. Mr Russell said he had not received any letters. The next day, he told the officer that someone from the mental health team should have seen him. The officer left a message on the mental health team's voicemail.

70. On 16 March, Mr Russell went to work and seemed in good spirits. A nurse from the prison's mental health in-reach team saw him in the afternoon and Mr Russell said he had been feeling up and down over the weekend and had banged his head against the cell door. He said that he sometimes felt unhappy and had thoughts of suicide. The nurse noted that Mr Russell appeared to be impulsive in his actions but showed no signs of psychosis and had no immediate plans to harm himself.

71. On 17 March, a supervising officer and an officer held Mr Russell's sixth case review. They described Mr Russell as "hyper" because he had not smoked for three days, but he was in good spirits because it was his partner's birthday the next day. Mr Russell said he wanted them to close the ACCT, but the supervising officer kept it open and scheduled a further ACCT review for 20 March. The supervising officer and the officer assessed Mr Russell as at low risk of suicide and self-harm. They left the level of observations unchanged, at one

entry each shift and four checks during the night. The SO did not update or change the caremap.

72. At 11.55am on 18 March, Mr Russell spoke to his partner and wished her happy birthday. (For security reasons, apart from legally privileged calls, all prisoners' telephone calls are recorded and staff listen to a random selection. The investigator obtained the recordings of Mr Russell's calls.) He told her he had been trying to contact her and, as a result, had spent all of his phone credit. Mr Russell complained that his partner did not visit him.

73. At 2.00pm, a friend of Mr Russell's called the prison and spoke to a custodial manager. She said that she was worried about Mr Russell because he had written to her and said that he wanted to kill himself. The custodial manager told the investigator that he passed the information to an officer on Houseblock Six. The custodial manager said that he had asked someone to speak to Mr Russell and that staff should monitor him for indications of a drop in mood, or anything which might cause concern. The custodial manager could not recall if he asked the officer to make a note in Mr Russell's ACCT. No one made a note of the concerns in the ACCT document, but the custodial manager recorded in Mr Russell's prison record that houseblock staff were aware of the concerns about him. The custodial manager said he went to Houseblock Six a day or two later to ask after Mr Russell. The custodial manager did not call Mr Russell's friend back as she did not give her number and did not ask him to get back to her.

74. Two nurses saw Mr Russell later that afternoon. Mr Russell said that he felt better and had not harmed himself since the previous week. At around 6.00pm, an officer noted that Mr Russell said he felt stressed about not getting any letters from his partner and was punching the window in his cell. The officer asked night staff to check him more frequently. Over the following days, no one recorded any further concerns.

75. At 2.00pm on 20 March, a supervising officer held Mr Russell's seventh case review on his own with Mr Russell. No other staff were present. The supervising officer noted that Mr Russell now had his partner's new address, had heard that his appeal would continue and was looking forward to starting a new education course. Mr Russell reported no thoughts of self-harm and SO Woodford closed the ACCT.

76. Two nurses saw Mr Russell later that afternoon. Mr Russell seemed bright and relaxed and had spoken to his partner the day before. He said he had no thoughts of suicide or self-harm but said that he wanted to see a psychiatrist. One of the nurses told him that the mental health team would arrange this. Over the following days, Mr Russell mixed well with other prisoners and no one recorded any concerns about him.

77. On 23 March, Mr Russell submitted a written complaint that another prisoner had assaulted him. He did not say exactly when this happened but said that he had complained about it three months earlier. He said that the other prisoner was still on his houseblock and that he felt intimidated by this and would be seeking compensation. There is no record of a previous complaint and there is nothing in his medical record to indicate that he had ever reported any injury to his nose. A

member of staff replied the next day and said that they had referred Mr Russell's complaint to a governor but there is no record of any further response.

78. On 27 March, a nurse from the prison's primary mental health team assessed Mr Russell to see which type of psychological treatment might be most appropriate for him. Mr Russell told her that he had mood swings, which frustrated him. He said that he felt tearful and was not sleeping well, and continued to punch or head butt the wall to relieve the stress. Mr Russell said he found it difficult to express his emotions and communicate with people. The nurse arranged for the mental health team to discuss Mr Russell at their next meeting.

79. A nurse from the prison's mental health in-reach team saw Mr Russell just after lunch and noted that Mr Russell continued to self-harm by punching and head butting his cell door, made ligatures to relieve anxiety and stress and appeared depressed. A further nurse prescribed Mr Russell five nights of promethazine, a sedative, because of his agitated state and thoughts of self-harm. The nurse wrote that Mr Russell had an appointment with a prison psychiatrist on 1 April. Neither of the nurses considered beginning ACCT procedures at the time.

80. Mr Russell telephoned his sister in the afternoon and early evening. His sister told him his mother had booked a visit for Easter Sunday (5 April.) Mr Russell said he was having problems contacting his partner and thought she was playing games with him. During one call, Mr Russell spoke to his mother and asked her to contact the prison chaplaincy to arrange an emergency visiting order for his friend. He also asked for some money, because he owed other prisoners two ounces of tobacco.

81. At 4.25pm that afternoon, two nurses and an officer agreed they should re-open Mr Russell's ACCT. One of the nurses noted that Mr Russell continued to head butt the cell wall and had made a ligature the previous night. Officers observed Mr Russell every hour until he could be assessed. The nurse noted in the ACCT record that an officer knew about the plans the mental health staff had made for Mr Russell, but no one recorded what the plans were.

82. At 9.00am on 28 March, Mr Russell moved to another single cell on B Spur. An officer noted that the move was because of his childish behaviour. The officer told the investigator that, in the days before, Mr Russell had played pranks on other prisoners, possibly instigated by others, in exchange for cigarettes. The officer said that he had arranged the spur move because he thought Mr Russell would find it easier to mix with the younger prisoners on B Spur. The officer said that there was nothing to suggest that Mr Russell was being bullied.

83. At 11.40am, a supervising officer held an ACCT review on his own with Mr Russell. No other staff attended, despite the fact that it was the mental nurses who had agreed the ACCT needed to be opened again. The supervising officer recorded that Mr Russell had had problems with a few other prisoners on A Spur. Mr Russell would not disclose the names of the other prisoners and the supervising officer did not record any further details about the problems, but wrote that Mr Russell seemed happy with the move.

84. The supervising officer noted in the ACCT caremap that Mr Russell had had difficulties with other prisoners, and that this difficulty had been resolved by the

move. He set the level of observations at three conversations each day and at least five checks during the night. He said that he could not begin any violence reduction procedures, as Mr Russell would not name the prisoners who were causing him problems.

85. During the investigation, a prisoner on Houseblock Six wrote to the investigator and said that around 25 March, two prisoners on A Spur began bullying Mr Russell for tobacco and medication. He said that the prisoners had told Mr Russell they would assault him if he did not comply.

86. Later on 28 March, Mr Russell collected his lunch and evening meal and mixed with other prisoners. He told an officer that he was okay. At 4.08pm, he telephoned his sister and said that his partner had not written to him. He told his sister that he had moved to B Spur because an officer had not believed him when he complained about some missing tobacco, so he had thrown a hot drink over the officer. (There is no evidence that this happened.)

87. At 9.05pm, the night patrol officer, an operational support grade, found Mr Russell holding a razor, which he threatened to use to self-harm. The night patrol officer persuaded Mr Russell to hand him the razor. The officer noted in the ACCT record that Mr Russell had slept through the night. No one considered whether there needed to be a review of his risk.

88. Over the next two days, staff recorded that Mr Russell seemed to be in good spirits and they had no concerns about him. Mr Russell was looking forward to his mother and brother visiting at the weekend.

89. On 31 March, an officer searched Mr Russell when he left work and found a roll of parcel tape, a bottle of surface cleaner, rubber gloves and other unauthorised items. The officer suspended Mr Russell from his job. Mr Russell said he had taken the items because he wanted then, but gave no other explanation about what he intended to do with them. The officer told the investigator that Mr Russell had not seemed upset about what had happened.

90. On 1 April, Mr Russell did not attend his appointment with the prison psychiatrist. No reasons were recorded and no one was able to explain to the investigator why he had not attended.

91. At 3.02pm on 2 April, Mr Russell phoned his sister and asked if she had heard from his partner, because she had not written to him recently. At 3.08pm, he phoned his mother and a family friend. Mr Russell told them he had lost his prison job and that people had been winding him up. At 3.48pm, he spoke to the family friend again and said he was going to get drunk on hooch that evening, as it gave him a buzz and blocked thoughts from his head. Mr Russell said his head was spinning and that his “heart said one thing while his head said another”, but that he could not tell officers how he was feeling. Officers recorded that he behaved normally that evening and they had no concerns about him.

92. At about 8.00am on 3 April, Good Friday, a supervising officer unlocked Mr Russell’s cell, but had difficulty opening the door because Mr Russell had jammed a piece of bedding in it. Mr Russell told the SO he had done something silly the previous evening. After the SO had finished unlocking the other

prisoners on the spur, she spoke to Mr Russell in the spur office. Mr Russell said he was concerned about his partner and that her new telephone number, which he had asked to be added the week before had not been added to his list of approved numbers and he had not received any letters from her. (We have checked Mr Russell's requests for telephone numbers to be added to his account and although there are records of other numbers being changed and added at the time, there is no record of a request for a revised number for his partner.) He said that he had still not received any post from her either. The SO explained that, as it was the Easter Bank Holiday weekend, she would not be able to find out anything about this until the next week. Mr Russell said he understood this. The SO told him to let staff know if he had any concerns or thoughts of self-harm.

93. While the SO and Mr Russell were talking, another prisoner (one of the prisoners who the prisoner from Houseblock Six had named as bullying Mr Russell) began banging on the office window. The SO asked staff to move the prisoner on. Mr Russell told the SO that the prisoner had been giving him a hard time on A Spur and that is why he had moved. Mr Russell said he had borrowed three cigarettes from the prisoner and that, when he had paid back six, the prisoner had demanded more. The supervising officer asked Mr Russell if he had had any further problems since he had moved. Mr Russell told her that he could not go out to the exercise yard to spend time in the open air, because others had told him that the prisoner planned to attack him with a weapon, which Mr Russell described as being made from a kettle plug. (Prisoners from A and B Spurs have the same allocated time in the exercise yard.) The supervising officer told him that this would not happen. When asked if he had any other concerns Mr Russell said he just wanted a job.

94. Later that morning, a nurse told the supervising officer that she had heard the other prisoner say that Mr Russell was informing on him. The supervising officer spoke to the other prisoner in his cell about his earlier behaviour. The prisoner became aggressive and assaulted the supervising officer. Staff restrained him and took him to the prison's segregation unit. A weapon, similar to that described by Mr Russell, was found in his cell. Officers who checked Mr Russell during the rest of the day noted that he did not mention any concerns and seemed okay.

95. On 4 April, Mr Russell collected his medication, mixed with other prisoners, and collected his meals as usual. Staff noted no particular concerns about him.

5 April 2015

96. At 7.30am on 5 April, Easter Sunday, an officer checked Mr Russell and noted that he was lying on his bed. CCTV footage shows that, between 11.15am and 11.23am, Mr Russell tied something around the hinge of his cell door. When other prisoners passed him on the landing, he went back into his cell, then came out again to continue what he was doing. No one saw what Mr Russell was doing. At 12.10pm, the officer wrote in the ACCT record that Mr Russell had been out of his cell during the day, but had raised no concerns with staff.

97. Mr Russell's mother, brother and friend visited him that afternoon. In a statement for the police, Mr Russell's mother said that he seemed very down and not himself, but he had been very happy to see them. She said that Mr Russell told

her that his partner was messing with his head, and that he did not want anything more to do with her. Mr Russell's mother said that she did not find her son's behaviour that day particularly unusual. He had told her during the visit, and at previous visits, that he was on "suicide watch" and had said that if he wanted to kill himself he would. She said that she did not have time to tell staff before leaving the visit, but that an officer had told her to ring the prison with her concerns. (Mr Russell's mother said that, on previous occasions, she had found it difficult to get the switchboard operator to put her through to anyone.)

98. None of the officers on duty on Houseblock Six that afternoon could recall having any significant contact with Mr Russell. They noted nothing unusual in the ACCT record. At 5.00pm, officers locked Mr Russell and the other prisoners on the spur in their cells.

99. At 5.05pm, an officer came on duty and took over from the day shift after receiving a handover. No one mentioned any particular concerns about Mr Russell. The officer checked all of the prisoners on the spur and noted in the ACCT record that Mr Russell was lying on his bed and said he was okay.

100. At 7.14pm, the officer was doing another ACCT check. The CCTV shows that he looked through Mr Russell's door observation panel for about 45 seconds. He could not see Mr Russell and shouted to try to get him to respond. He then noticed something that he thought was an arm or shoulder blocking part of the observation panel. He realised something was wrong and radioed a code blue emergency. (A code blue indicates a life-threatening situation such as when a prisoner is unconscious or not breathing.)

101. For security reasons, staff on duty in residential units at night do not carry standard prison keys but have a cell key in a sealed pouch for use in an emergency. The officer had difficulty breaking the plastic seal on the pouch to get the emergency key. As he was trying to break the seal, a supervising officer and an officer arrived. (According to the CCTV, this was 7.16pm.) As they approached, the officer shouted to them to open the cell door quickly as he thought Mr Russell was hanging.

102. The supervising officer and officer went into the cell and found that Mr Russell had hanged himself from a ligature made of bedding, tied to the door hinge. The supervising officer and the officer took the weight from Mr Russell's body and cut the bedding from around his neck. They then laid him on the floor in the recovery position. They were unable to find a pulse, so moved him onto his back and started cardiopulmonary resuscitation.

103. The control room log indicates that staff called an ambulance shortly after the officer radioed the code blue. The officer said when the other officers arrived someone (he thought the supervising officer) shouted for an ambulance to be called. The officer ran to the office, telephoned the control room, and asked for an ambulance, although he had understood that control room staff would have called an ambulance automatically, after he had radioed the code blue. An operational support grade and an officer were working in the control room. The operational support grade said the officer had called for an ambulance straight away in line with national instructions. (Although there was a slight discrepancy

in times between the CCTV and the written log, we are satisfied that there was no real delay.)

104. A nurse arrived at the cell with emergency response equipment, two and a half minutes after the officer radioed the code blue. He attached a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) but it found no shockable heart rhythm. The nurse and two more nurses who arrived a few minutes later, continued cardiopulmonary resuscitation.

105. At 7.31pm, paramedics arrived at Mr Russell's cell, administered emergency treatment and managed to re-establish a pulse. At 8.13pm, they took Mr Russell to outside hospital.

106. Mr Russell remained on life support, in a critical condition overnight, but sadly, he never regained consciousness. The next morning, 6 April, the life support machines were switched off. At 10.05am, doctors pronounced Mr Russell dead.

107. Mr Russell had left notes in his cell addressed to his children, his mother and his partner. He apologised for his actions but said that he could not take it anymore.

Contact with Mr Russell's family

108. The prison's Head of Residence and Safety was the duty governor on the evening of 5 April. He said he decided to wait for Mr Russell to arrive at the hospital and for an initial prognosis from doctors, before informing Mr Russell's family what had happened. At 9.20pm, he spoke to a prison chaplain who acted as the prison's family liaison officer and asked her to come to the prison, where he briefed her about what had happened. Mr Russell had named his mother as his next-of-kin when he arrived at High Down, but in his ACCT document had named his partner. He decided that they should contact his mother first.

109. At 12.30am on 6 April, the prison chaplain arrived at Mr Russell's mother's home. She explained what had happened and that Mr Russell was in a critical condition in hospital. She accompanied Mr Russell's mother to the hospital and other family members joined them. Members of Mr Russell's family were at his bedside when he died.

110. High Down asked staff at HMP North Sea Camp to break the news to Mr Russell's partner. She was not at home and eventually, Mr Russell's sister told her he had died. The prison chaplain remained in contact with Mr Russell's family after his death. The prison held a memorial service and offered to contribute to the cost of Mr Russell's funeral in line with national policy.

Support for prisoners and staff

111. On 8 April, managers debriefed the prison staff involved in the emergency response. Staff involved said they found it helpful and that the prison's care and welfare team had given them good support. However, the nurses who responded were not invited to the debrief. The prison posted notices informing other prisoners of Mr Russell's death and offered support. Officers reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of Mr Russell's death.

Findings

Management of risk of suicide and self-harm

112. Before he went to prison, Mr Russell had a history of self-harm by cutting, banging his head, overdosing and tying ligatures around his neck. Staff managed him under ACCT procedures for most of his time at High Down. We have identified a number of deficiencies in the management of ACCT procedures at High Down, which we set out in more detail below. We cannot know that better procedures would have altered the outcome for Mr Russell but we do not consider that High Down managed Mr Russell's risk effectively, in line with Prison Service national policy and procedures. We are concerned that HM Inspectorate of Prisons identified many of the same weakness in ACCT procedures at a recent inspection of High Down.

ACCT reviews

113. The ACCT assessment interview carried out on 18 February was of a good standard, and helped identify Mr Russell's main concerns. Subsequent ACCT case reviews were not of a good standard and we note that neither of the ACCT assessors attended the first case reviews, as Prison Service Instruction (PSI) 64/2011 advises. Mr Russell had eight ACCT case reviews, none of which was multidisciplinary. PSI 64/2011 requires a multidisciplinary approach for case reviews and it is mandatory for a member of healthcare staff to attend at least the first ACCT case review. There were no healthcare staff present at Mr Russell's first ACCT case reviews or at any subsequent reviews.

114. We are concerned that there is no record that healthcare staff were invited to ACCT case reviews, despite Mr Russell's mental health problems. He was under the care of the mental health team and a nurse saw him frequently. The nurse should have been involved in decisions about his risk of suicide and self-harm as part of a multidisciplinary team. Some of the staff who chaired or attended the reviews had little personal knowledge of Mr Russell, yet staff, who did know him, such as chaplaincy staff and instructors, were not invited. A number of the officers who attended said that this was simply because they happened to be on duty at the time, rather than because they had any particular knowledge of Mr Russell.

115. We are particularly concerned that two of the ACCT reviews were held with just one member of staff, including one on 20 March when a supervising officer acting entirely alone, decided to close the ACCT without any input from other staff, including the mental health team, who knew Mr Russell. This is very poor practice. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff.

116. Many of the records of case reviews appeared perfunctory and did not address Mr Russell's needs or risk. Issues such as alleged bullying and its potential impact on his risk were not discussed. When Mr Russell's friend contacted the prison, concerned about his state of mind, this was not entered in his ACCT records or discussed at a case review. There were a number of times when we

would have expected staff at least to have considered bringing forward scheduled case reviews to review Mr Russell's risk after he self-harmed or showed signs of increased risk, but this did not happen.

Observations and interactions

117. While Mr Russell was being monitored under ACCT procedures, there were occasional changes to the frequency of required observations but most of the time, staff were required to record one quality observation or conversation three times during the day and check him five times during the night.

118. We were surprised that, even when Mr Russell's level of risk was assessed as raised, the frequency of required observations and checks were relatively low and did not reflect his risk. On 23 February, 26 February and 27 February, he had tied ligatures around his neck, or thought of doing so. Despite this, the level of checks remained at just three recorded conversations during the day and either four or five at night. The investigator reviewed a number of other ACCT documents at High Down and found that this level of required observation was standard, almost irrespective of the risk of suicide and self-harm. Some staff told us that they considered that if prisoners needed more frequent observations than this, they should be admitted to the prison's healthcare inpatient unit.

119. PSI 64/2011 stipulates that staff must follow the level of observations and conversations as stated on the front cover of the ACCT and that observations must be conducted at unpredictable intervals. We found several times when staff did not check Mr Russell at the required frequency, when the level of observations was increased. On 18 February, when staff were expected to check him hourly, no one checked him for over two hours. On 23 February, there was a gap of almost an hour and a half, when staff were expected to check him at least twice an hour. This might be partly be explained by the fact that observations were not clearly recorded or kept up to date on the front cover of the ACCT document. We also noted that, when the frequency of checks was increased to hourly, too many of the checks were at regular and predictable intervals.

Caremaps

120. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. Caremaps should aim to address issues identified in the ACCT assessment interview and consider a range of factors including health interventions, peer support, location, provision of diversionary activities, including occupations in cell and access to gym and other activities. Each action on the caremap must be tailored to meet the individual needs of the prisoner, be aimed at reducing risk to themselves, be time bound and state who is responsible for completing the action.

121. During Mr Russell's second period of ACCT monitoring, no one revisited the caremap or updated it after the first case review on 18 February, apart from an entry on 28 March, which noted that Mr Russell had moved spurs. There is no record or other evidence that case reviews discussed or referred to the caremap, in particular when the ACCT was re-opened on 5 March. There is no record that

the issues and concerns Mr Russell raised were addressed or new targets set as they arose, such as when Mr Russell's alleged he had been bullied.

122. While there is evidence that some staff had a caring approach, such as telephoning Mr Russell's partner on his behalf, there was a lack of sound structured approach through effective clearly targeted actions aimed at reducing his risk. Some caremap objectives, such as a referral for a mental health assessment are a useful first step, but referrals on their own, do not reduce risk or help ensure that identified issues are addressed.

123. We make the following recommendation:

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

- **Case reviews should be multidisciplinary, attended by all relevant people involved in a prisoner's care and ensure continuity of case management. A member of healthcare staff should attend all first ACCT case reviews.**
- **Reviews should assess the level of risk taking into account all risk factors including the impact of issues such as bullying. New reviews should be held when there is evidence of significant change in risk such as further plans or acts of self-harm.**
- **Levels of observations should reflect the risk, should be adjusted when risk changes. Staff should carry out and record all observations as required.**
- **Case managers should set caremap actions which are specific and meaningful, identify who is responsible for them and should review progress against caremaps at each review.**

Bullying

124. On 28 March, Mr Russell said that he was having problems with other prisoners on A Spur. He would not name the prisoners but agreed to move to B spur. On 3 April, he told a supervising officer that he was in debt to another prisoner on the houseblock and feared being attacked by him. He named the other prisoner, who he claimed was expecting an extortionate return for borrowed cigarettes, which he had already repaid in double the number borrowed. As a result, he was afraid to spend time in the open air in the exercise yard, where he might encounter the other prisoner. Later that day, the other prisoner assaulted the supervising officer and was moved to the segregation unit. It seems that staff were reassured that Mr Russell would not face any further problems. No one took any formal action to investigate Mr Russell's allegations and he was not offered any specific support, other than verbal reassurance.

125. Mr Russell died just eight days after his move to B Spur. In our Annual Report 2014-15, we highlighted that, often, bullying played a part in a self-inflicted death. Too often, we find that prisons do not identify concerns or take appropriate action to address them. Ultimately, the prisoner who had been threatening Mr Russell was moved from the houseblock for other reasons. However, there was no investigation to determine whether other prisoners were involved. It is possible

that Mr Russell's concerns negatively affected his state of mind. A proper review and investigation, coupled with adequate support might have helped address any anxiety.

126. At the time of Mr Russell's death, High Down had no formal victim support policy. In the report of an inspection of High Down in January 2015, HM Inspectorate of Prisons identified that there was a need to improve the management of perpetrators and the victims of violence and noted there was no formal support for victims of violence or bullying. We understand that High Down is now addressing the issue of victim support.

127. The prisoner who Mr Russell said was threatening him was not vulnerable by the nature of his offence, but was housed on the vulnerable prisoners' unit for other reasons. We recognise that it can be difficult for staff to manage such a mix of prisoners. We consider that this made it even more important for staff to be vigilant about any signs of potential bullying on Houseblock Six and to actively challenge and promptly deal with anti-social and threatening behaviour by prisoners located on the unit for different reasons. We make the following recommendation:

The Governor should ensure that there are appropriate violence reduction procedures, including to protect prisoners in the vulnerable prisoners unit at risk from others in the unit, which are used actively, promptly and effectively to challenge prisoners suspected of bullying behaviour and to support their victims.

Clinical care

128. When Mr Russell was received at Doncaster in June 2013, his medical record referred to a drug overdose in 2007, attention deficit hyperactivity disorder (ADHD) in 2008, and paranoid disorder in 2009. His prison medical records also mentioned autism, possible learning difficulties, mood changes leading to self-harm (usually head banging and making ligatures) and bipolar affective disorder. In September 2013, he had been detained under the Mental Health Act for "mixed personality disorder'. He had no history of any significant drug or alcohol abuse. There is no record that Mr Russell had any clear psychiatric diagnosis.

129. The clinical reviewer concluded that when Mr Russell arrived at High Down he received an appropriate medical assessment at reception and efforts were made to establish his medical history. Information was appropriately shared with the mental health team.

130. A prison GP diagnosed Mr Russell with severe depression and prescribed fluoxetine, which was appropriate. However, the clinical reviewer found that there was no review of his medication, despite Mr Russell's self-harm and reporting to a nurse that he considered the fluoxetine was ineffective.

131. It appears that Mr Russell had been diagnosed with ADHD some years previously but was not being treated for this at the time he went to prison. The clinical reviewer said that a GP would need a specialist assessment and a psychiatric referral before beginning treatment for ADHD again for an adult.

132. Mr Russell had an appointment with a psychiatrist on 1 April, which the clinical reviewer noted was a lot quicker that would happen in the community. However, Mr Russell did not attend and no reasons were recorded in his medical record. A nurse who was responsible for his care was unaware of this at the time. We understand that the Central North-West London NHS Foundation Trust, which is now responsible for mental health services at the prison had addressed this matter and issued new guidance about managing non-attendance at appointments.

133. The clinical reviewer was concerned that that there was insufficient team communication or collaborative working. Although a nurse from the mental health team saw Mr Russell frequently for support, there was a lack of recorded risk assessments and structured coordinated care plans. There was no record that Mr Russell's management was discussed at weekly mental health multidisciplinary team meetings and GPs did not attend the meetings. The clinical reviewer has made a number of detailed recommendations for improved practice in his clinical review, which the Head of Healthcare will need to address, including about training, record keeping, medication reviews, sharing information and post-incident support. The clinical reviewer concluded that despite Mr Russell having some complex mental health issues, they were not addressed as comprehensively as he would have expected. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with complex mental health problems, under the care of the mental health in-reach team, have structured and coordinated care plans, which are shared with all relevant staff and that their management is discussed at multidisciplinary team meetings.

Family liaison

134. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "***at once*** inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed".

135. When Mr Russell was taken to hospital at 8.15pm on 5 April, it was evident that he was in a critical condition and the prison should have informed his family straight away. However, the prison waited for further updates and then went in person to see Mr Russell's mother. We accept that this was done with good intentions but any delay in informing families when a prisoner is seriously ill or has suffered sudden life-threatening harm can mean that families miss the opportunity to see them before they die. No one from the prison informed his partner that he had been taken to hospital, although Mr Russell had named her as his next of kin in his ACCT document. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.