PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

# A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

**Investigation into the death of a man in September 2013 at HMP Whitemoor**

## *Our Vision*

*'To be a leading, independent investigatory body,*
*a model to others, that makes a significant contribution to*
*safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in his cell in HMP Whitemoor in the early hours of 9 September 2013. He was 46 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care in custody. HMP Whitemoor cooperated with the investigation.

The man had been sentenced to life imprisonment in December 2011 and arrived at Whitemoor in July 2012. Two months later, he attempted suicide by hanging and was taken to hospital. When he returned from hospital, he was admitted to Whitemoor's healthcare centre. He remained there until the end of the year and received a high level of support from the mental health team. In May 2013, it was agreed that the mental health team could not help him any further, but his mental health records contained a crisis plan which specified that, if he expressed any distress to wing staff, the man should be subject to constant observation. This was not shared with prison staff and was not noted in his primary healthcare records.

On 8 September, the man's partner spoke to him by telephone and ended the relationship. The call had been monitored and security staff informed wing staff. The man said that he was okay, but staff began to monitor the man under suicide and self-harm prevention procedures which required him to be checked twice an hour during the night. At a check in the early hours of the morning, an officer found the man had hanged himself using shoelaces tied to the window security cage.

The clinical reviewer considered that the level of mental healthcare the man received after his suicide attempt in 2012 exceeded that he could have expected in the community. However, I share the reviewer's concern that the crisis plan devised by mental health staff was not shared with other staff who needed to know.

Prison staff were responsive and proactive in implementing support measures when they discovered that the man had received unwelcome news. Sadly, these efforts were unsuccessful. When he was found hanging, resuscitation attempts were skilful, but I am concerned that officers did not feel confident that they could enter a cell immediately in an emergency and that Whitemoor has not followed mandatory Prison Service instructions to ensure an ambulance is called immediately an emergency code is used.

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

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **May 2014**

**CONTENTS**

## SUMMARY

1. The man was 46 years old and was serving a sentence of life imprisonment for which he had been in custody since April 2011. He had been in prison before.

2. Initially, no one had considered that the man was at risk of suicide or self-harm but, in September 2012, two months after he arrived at Whitemoor, the man attempted to kill himself in his cell by hanging. Staff were able to resuscitate him and he stayed in hospital for six days. When he was discharged he was admitted to the prison's healthcare centre and gradually reintegrated into the main prison. He returned to a residential wing in December. The mental health team remained in close contact with the man and provided a high level of support. He could not explain why he had tried to take his own life and claimed to have no memory of the incident. The mental health team was unable to identify what had triggered his actions.

3. In May 2013, the mental health team discharged the man from their care but noted on his mental health record that if he expressed any distress to wing staff, he should be put on constant supervision. This was never communicated to wing staff or other healthcare staff. The man seemed to settle well and there were no concerns about his behaviour or compliance with the prison regime. He was worried about impending extensive dental treatment, but he did not give any cause for concern that he might harm himself.

4. On 8 September, security staff conducting random monitoring of prisoners' telephone calls overheard the man's partner telling him that their relationship was over. They informed wing staff, who spoke to the man. He insisted that he was all right and did not appear to be distressed by the news. However, the wing manager decided that he should be monitored under suicide and self-harm prevention procedures, as a precaution and to provide extra support. The wing manager decided that the man should be checked at least twice an hour.

5. Officers observed the man as expected. At 12.20am on 9 September, an officer noted that he was pacing up and down his cell in the dark and did not respond when the officer spoke to him. The officer therefore made an extra check, when the man was watching the television and smoking and appeared more settled. When he checked him at 1.17 am the man was asleep but woke up. At 1.50am, the officer found the man hanging. He did not go straight into the cell, but went to the wing office to telephone for emergency assistance. Support arrived quickly but an ambulance was not called until an officer trained in first aid requested one. The staff attempted to resuscitate the man. Paramedics continued to try to resuscitate the man for some time after they arrived, but were unsuccessful.

6. The post-mortem examination showed that the man's system contained a level of alcohol that would indicate a degree of drunkenness in a moderate drinker. Several months before his death, he had denied drinking hooch, when challenged. There was no evidence of any alcohol in his cell.

7. The investigation found that the man received a high level of mental healthcare, exceeding that he could have expected in the community. However, there were shortcomings in healthcare and the sharing of information between the primary care and mental health teams and prison staff, which meant that relevant

people were unaware of the detail of the man's crisis plan. We are also concerned that Whitemoor did not have a local protocol for medical emergencies, in line with mandatory Prison Service instructions. This meant that an ambulance was not requested automatically when the emergency code was called.

## THE INVESTIGATION PROCESS

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

9. The investigator obtained the man's prison and medical records. He visited the prison on 17 September 2013 and spoke to the deputy governor and other prison staff about the background to the man's death.

10. East of England NHS commissioned a clinical reviewer to review the man's care and treatment in custody. The investigator and clinical reviewer jointly interviewed healthcare staff and they discussed the clinical reviewer's findings.

11. The investigator interviewed 12 members of prison staff and one prisoner. He gave preliminary feedback to the Governor of Whitemoor during the investigation.

12. We informed HM Coroner for North and East Cambridgeshire of the investigation who provided the post-mortem report. We have sent a copy of this report to the Coroner.

13. One of our family liaison officers contacted the man's sister to allow her to identify issues she wished the investigation to cover. The man's sister asked about the procedures for monitoring those suspected of being at risk of suicide and whether he should have been allowed items in his cell that he could have used to harm himself, such as shoelaces. She said that the prison's family liaison officer had been helpful. The man's sister received a copy of the draft report. She provided feedback, some of which has led to an amendment to the wording of paragraph 81.

14. NOMS received a copy of the draft report. Their response is added at the end of this report.

## HMP WHITEMOOR

15. HMP Whitemoor is a high secure prison which holds over 400 category A and B prisoners serving four years or more. NHS Cambridgeshire commissions healthcare services. Cambridgeshire and Peterborough NHS Foundation Trust manage the prison's mental health provision.

### Her Majesty's Inspectorate of Prisons

16. The most recent inspection report of Whitemoor is of an inspection in January 2011. The report of a more recent inspection has not yet been published. The Inspectorate considered that healthcare was reasonably good, but primary mental health services were too limited to meet needs. Inspectors found excellent joint working between healthcare and other prison departments.

17. The inspectorate found that Whitemoor was safer than at a previous inspection in 2008 and that prisoners at risk of suicide and self-harm were well cared for. Prisoners said that they felt safer than previously. Inspectors found that mental health input into suicide prevention procedures was inconsistent and support plans for those at risk of suicide or self-harm were not always good quality.

### Independent Monitoring Board (IMB)

18. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure that proper standards of care and decency are maintained. The most recent IMB report for Whitemoor for the year up to July 2013, noted that the mental health in-reach team had moved into the main office in the healthcare centre and that this had enhanced interdisciplinary working.

### Previous deaths at Whitemoor

19. The man was the second prisoner to take his own life in Whitemoor since 2008. The previous death in September 2012 was of a man who had been a friend of the man and was also serving a life sentence. The man had attempted to hang himself less than two weeks after his friend's death, but survived after staff found him and he was resuscitated.

### Suicide and self-harm prevention monitoring

20. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions on the caremap have been completed. Under the ACCT procedures, staff should also consider whether to remove any items the prisoner might use to harm himself such as shoelaces but the removal of such items should be kept to a minimum.

## KEY EVENTS

21. The man was born on 13 March 1967. The man had numerous of criminal convictions and had previously served a four-year prison sentence for robbery. He drank heavily, which had led to many major physical health complications. In 2009, he was placed in a medically-induced coma after suffering alcoholic seizures and he said that this had affected his memory. There is no indication that he had a history of self-harm.

22. In April 2011, the man was charged with murder and remanded to HMP Wandsworth. At his reception health screen, he said that he was not a drug user and had never had any feelings of wanting to harm himself. He had seen a psychiatrist and received treatment for mood swings. The doctor listed his medical conditions, but found no signs of mental health problems.

23. The man transferred to HMP Belmarsh in May. The reception health screen again noted no concerns about suicide and self-harm. The man agreed to go to an Alcoholics Anonymous (AA) meeting for psychological support. On 10 May, he completed an alcohol detoxification programme but changed his mind about attending AA.

24. In December, the man was sentenced to life imprisonment, with a minimum time to serve of 28 years before he could be considered for release. When he returned to the prison from court, a nurse noted that he was quiet and calm. He said that he felt fine and had no plans to harm himself.

25. The man had a mental health review in March 2012. In April, he had three meetings with a counsellor and agreed to see a personal support worker to help manage anxiety. A note in his record on 18 May showed that he was making good use of these sessions. During May, the man was found guilty of a disciplinary offence after failing a mandatory drug test.

26. The man transferred to Whitemoor on 17 July. After a reception health screen, the doctor re-prescribed his medication for his existing medical conditions.

27. On 13 September, a friend of the man's at Whitemoor took his own life. The next day, the man told a nurse that he was sad about what happened and she advised him to speak to nurses or chaplains if he needed help. She told wing staff that although the man seemed all right at the time, it was possible that he might become upset.

28. On 17 September, a nurse asked the man how he was coping, as she dispensed his medication. He told her he was fine. The nurse said he made good eye contact and appeared to be cheerful but she noted that she would speak to the doctor, mental health team and managers the next day because she was concerned that he seemed to be finding it difficult to come to terms with his sentence. The man had an appointment scheduled with the doctor for 26 September, but she planned to discuss whether it should be brought forward. There is no evidence that this was done.

29. At 1.55am on 25 September, during a routine check, an officer found the man hanging in his cell from a ligature made from shoelaces tied to the window security cage. The top half of his body was hidden from view as he had put a

sheet over the window. Staff resuscitated him and an ambulance took him to hospital, where he was placed into a medically-induced coma. He had left a suicide note in his cell, addressed to his partner.

30. At an assessment with the hospital's psychiatric team, the man said he did not have any suicidal thoughts. The assessment identified no issues around self-confidence, worthlessness, helplessness or hopelessness. When asked about his long sentence he said that he just had to accept it and move on. He said that he had no memory of his suicide attempt or the day leading up to it. The psychiatrist considered that he was not depressed, but he still presented a high risk to himself. The psychiatrist recommended that when he returned to prison, The man should be admitted to the healthcare centre, monitored under suicide and self-harm prevention procedures and should be referred to the prison's mental health in-reach team.

31. The man returned to Whitemoor on 1 October, with a detailed management plan. An ACCT was opened and he was constantly supervised in a gated cell in the healthcare centre. On 4 October, the man told a psychiatrist from the mental health in-reach team that he did not remember his suicide attempt, or writing the suicide note and he had no idea why he did it. He had not previously self-harmed and had no known mental health problems, though he had said that since a coma in 2009, he was forgetful. The man said that he had been with his partner for three years and they spoke to each other every day. He felt well, said he had no suicidal thoughts, displayed a positive outlook and showed no evidence of low mood. The psychiatrist judged there was no need for anti-depressants, but the plan was that the in-reach team would work with the man to try to understand what had triggered his suicide attempt.

32. The man remained in the healthcare centre, in close contact with psychological services and maintained that he did not recall his suicide attempt. His psychologist suggested that further assessments might be necessary to assess the impact alcohol had had on his memory. The man gradually reintegrated to a normal residential wing by working on the wings during the day but returning to the healthcare centre each night. On 17 October, a community psychiatric nurse (CPN), completed a care plan in line with the NHS Care Programme Approach for people experiencing mental health problems. As a part of this process, he wrote to the man's former GP to ensure he had a full medical history. The doctor replied on 31 October, detailing medical information for the period August 2007 to May 2009, including memory lapses due to alcohol and drug misuse. The information received was held in the mental health in-reach team records, but not shared with the primary care team or noted in the man's general medical record.

33. A clinical psychologist, assessed the man on 1 November and noted that the man said he did not recall his suicide attempt, was very shocked by what he had done and thought something must have snapped in his head. The clinical psychologist noted that the man did not engage in detailed exploration or discussion about emotions and added, "needs to be an ongoing understanding between all staff about who is to fulfil the role of checking with [the man] his overall progress". A note on his psychology record the next day shows that a member of the mental health team had reviewed The man and found there were no identifiable concerns such as depressive illness. On 5 November, a psychiatrist examined the man and confirmed that there were no signs of

mental illness and no specific psychiatric treatment was required but this would be kept under review. The same day, the man told a psychologist, that he had no suicidal thoughts and he seemed positive about the future. The psychologist and the mental health nurse agreed they would see him weekly.

34. On 8 November, the man learnt that his appeal against his conviction had been refused. The same day, he had a difficult telephone call with his partner, who told him that their relationship was over. When he saw the psychologist on 13 November, he said that he and his partner often argued. A psychologist explained they were concerned about his ability to cope and this was particularly difficult without an identified trigger of what might cause him to harm himself again.

35. On 14 November, prison staff told the man that he would be moving from the healthcare centre to a residential wing. They showed him the cell they proposed to move him to but the man was not happy about the move and commented, "I'll show them how far I can go". This was taken as a threat to harm himself again so the staff allowed him to return to the healthcare centre where he was constantly supervised in the gated cell. He returned to a standard cell the following day.

36. At an ACCT case review on 19 November, after receiving information from an operational manager that staff had smelled alcohol on the man's breath, an officer asked whether the man had been drinking "hooch" (illicitly brewed alcohol). The man emphatically denied this. The review team offered him the support of the drug and alcohol team and agreed the matter would be discussed outside the ACCT process. The man left the healthcare centre later that day and returned to a residential wing.

37. The man settled well on the wing and his ACCT plan was closed on 27 November. At the post-closure interview, staff noted that he was still working with the mental health team to try to understand his actions. He was hoping to gain enhanced status under the Incentive and Earned Privileges scheme (which allows extra privileges for good behaviour and compliance with sentence plans targets) and buy a PlayStation. He continued to engage with psychology services and on 3 December, he told the psychologist that he had no problems. He was pleased that the ACCT monitoring had ended and he was still trying to make sense of his suicide attempt. The next day, the man asked for a transfer to the Close Supervision Centre to get treatment for his personality disorder and aggressive behaviour. (Close Supervision Centres are for the most dangerous and disruptive prisoners in the prison system and the man would not have met the criteria.)

38. A psychological assessment on 12 December showed that the man had an IQ within the normal range, but his score on memory was lower than expected in relation to his IQ. The man seemed keen to understand what had happened when he had hanged himself, so that he could prevent it happening again. However, he also wanted to ensure that his curiosity about it was not taken as an indication that he was at risk of wanting to repeat it or that he was fixated about suicide.

39. In January 2013, the man began to see the drug and alcohol rehabilitation team about his alcohol use. He attended a recovery programme for substance

misusers. Records show that although he found some parts of the programme difficult, he worked at it and was willing to accept help.

40. On 18 March, A member of staff from the mental health team reviewed the man's care plan. He concluded that they would not make any further progress in identifying what had triggered his suicide attempt. He recorded a crisis plan that if the man expressed any distress to wing staff, they should place him on constant supervision and inform the healthcare and mental health teams. The same day, the man saw the psychologist, who noted that his mental state was stable and he needed no further input from the in-reach team.

41. On 21 March, the man told an officer, his personal officer (a first point of contact and support) that he felt as though a great weight had been lifted from his mind since talking things through on his offending behaviour courses and his outlook on life felt more positive. When the officer moved to work on a different wing in April, another officer took over as the man's personal officer.

42. On 19 April, the man's psychiatrist saw him and noted that he had no mental disorder and did not need continuing input from the in-reach team. Although the man had cognitive and memory problems, his mental state at that time was very settled. He had no problems with changing moods, reported no ideas of suicide and had not harmed himself. The psychiatrist suggested that the memory clinic consider more detailed scans of his brain. On 21 May, the mans personal officer noted that the man displayed a positive outlook and staff continued to monitor his moods. He enjoyed his job in one of the workshops and on 5 June, he achieved enhanced regime status.

43. A note in the wing observation book on 31 July showed that the man had had a bad telephone call. The officers on the wing were asked to monitor him.

44. The man was due to begin extensive dental treatment in hospital but on 27 August, he asked a nurse to cancel the appointment as he was frightened. The nurse passed this information to the deputy healthcare manager. On 30 August, the man told a nurse that he would not go to hospital as planned the following week. The nurse referred this to one of the prison doctors. The doctor had an appointment scheduled with the man for 2 September to discuss this. However, the man subsequently did not attend this appointment as there was a locum doctor instead of the doctor and he did not want to see anyone else.

45. An entry in the wing observation book on 3 September indicated that, as part of his crisis plan, the man should not be left in his cell unoccupied if he was not required for work. An officer explained to the investigator that she had put this in the observation book as the man had pointed out to her that his crisis plan said he should not be left alone in his cell during activity periods. He had shown her the relevant part of the plan. Wing staff contacted the healthcare centre, but healthcare records do not show any contact with him that day. The officer subsequently spoke to the man and thought he seemed in a low mood. He said that he was just tired as he had been playing his PlayStation all night.

46. At an appointment on 5 September, the man told the doctor that he did not want to go to hospital for his dental treatment. The doctor had no concerns about the man's mental state but wanted to explore the options to ensure he could have

the dental treatment he needed. He made another appointment to see him the next day but the man did not attend. There is no record to explain the reason.

47. The man's partner visited him on Saturday, 7 September. There is no information about how the visit went. During the afternoon of Sunday 8 September, the man telephoned his partner several times. She had been locked out of her flat and appeared irritable and argumentative during the calls. Eventually, at 3.29pm, she told the man that the relationship was over. He tried to call her back several times, but she had switched her telephone off.

48. All prisoners' telephone calls are recorded, but only ten per cent are monitored. The man's telephone call happened to be one of those monitored that afternoon. When the security staff monitoring the call heard that it involved a relationship break up, they informed staff on the man's wing. A Supervisory Officer (SO) took the telephone call and passed the information to the wing custodial manager.

49. Although the man's demeanour seemed normal and he had told staff that he was okay, the custodial manager knew that he had made a serious suicide attempt a year earlier. He therefore decided they should monitor him under ACCT procedures and informed the duty governor.

50. After the telephone call, the man had returned to his cell, where he briefly played on his PlayStation with another prisoner, before they were locked into their cells for the night at approximately 4.20pm.

51. At 5.45pm, an officer made a note in the wing observation book to alert all staff that the man was on an ACCT plan and might need support. As prisoners had been locked in their cells for the evening, the officer spoke to the man through his cell door. He was sitting on the bed playing his PlayStation and he told her that he was okay. The officer felt he was acting normally and had no concerns about him at the time. The officer completed the "concern and keep safe" section to initiate the ACCT and the custodial manager completed the immediate action section plan. The purpose of the immediate action plan is to consider and record the most appropriate environment and regime to support the person at risk before the first case review is held. At night, staff were expected to check the man twice per hour and record this in the ACCT document. During the daytime, the expectation was one observation and one conversation an hour when prisoners were unlocked. The custodial manager then completed the other administrative tasks required when opening an ACCT and ensured that wing staff were aware of the observation requirements.

52. The officer came on duty as the night officer for A wing. The custodial manager briefed him on the man's circumstances and ensured that he was aware of the observation requirements. The officer knew the man as he had been his personal officer when he had attempted to take his life the previous September. At approximately 7.35pm, another custodial manager, came on duty and took over as night manager. The custodial manager briefed the other manager and his deputy night manager, a SO, about ongoing issues including the man's ACCT plan and the requirements for monitoring.

53. The ACCT record shows that staff checked the man at the required intervals. The prisoner in the neighbouring cell told the investigator that the man was

playing music in his cell between about 8.00pm and 9.00pm. When the officer checked at 8.40pm and 9.10pm, the man did not respond when he spoke to him. At 9.44pm, when an operational support grade (OSG) carried out a check and asked if he was okay, he replied, “Do I sound all right?”. At 10.38pm, the officer saw him asleep, at 11.20pm he was in bed with his eyes closed and at 11.48pm again appeared to be asleep.

54. When the officer checked the wing at 12.20am on 9 September, he went to the man’s cell first. The cell lights were off so he shone his torch into the cell and saw him pacing around in the dark. The officer asked if he was okay but the man did not respond. The officer knew that the man would normally acknowledge him when he spoke to him. He was pacing back and forth and, although he had not harmed himself, the officer felt that this behaviour was not normal. Because of this, after he had finished his checks of the wing at 12.35am, he went back to make an additional check on the man. By this time, the man he was watching television and sitting on his bed smoking. When the officer opened the observation panel, the man turned and looked at him but he did not speak or otherwise acknowledge him.

55. The officer next checked the man at 12.55am when the man was lying on his bed watching television. When the investigator interviewed him, the officer said that he felt that the man was now behaving more normally than at the 12.20am check. At 1.17am, the man was asleep on his bed but woke up when the officer shone his torch into the cell to observe him.

56. When the officer made his next check just before 1.50am, he could not see the man in the bed when he looked through the observation panel. He noticed that the locker and chair that had been against the back wall had been moved and he then saw the man’s legs underneath the curtain, facing the window. His feet were hidden by the chair. The officer turned on the cell light and knocked on the door, calling the man’s name, but he did not respond. He ran to the office to telephone the control room, and they called a code blue emergency, indicating a prisoner is unconscious or has breathing difficulties. He then telephoned B wing, the nearest to A wing, and asked an officer to come and help him. The control room log shows that the call from the officer was at 1.48am and the code blue call went out immediately on the radio network. The night orderly officer, deputy night orderly officer and the duty nurse all responded by radio within a minute to say that they had received the message and were on their way.

57. Staffing levels are lower at night than during the day, as prisoners are locked in their cells. For security reasons at night, prison staff on the wings do not carry a set of keys but have a cell key in a sealed pouch, for use in an emergency. Usually staff should not go into cells during the night unless the night orderly officer and other staff are present but, in the event of an emergency, the local security guidelines say that staff should not be deterred from entering a cell subject to a risk assessment of the situation.

58. The officer decided not to enter the cell without additional staff. Another officer arrived, shortly followed by the night orderly officer and deputy night orderly officer at 1.50am. The officer had broken the seal on his key pouch ready to open the cell.

59. The manager, SO and the two officers went into the cell. One officer moved the curtain and they saw the man hanging from a ligature made from shoelaces tied to the security cage over the window. The officer lifted the man, cut him down with his anti-ligature knife and laid him on the bed. The manager was a trained first-aider and checked the man for signs of life. He found none, so he and the SO began cardiopulmonary resuscitation (CPR).

60. The manager asked someone to tell the control room to call an ambulance and one was requested at 1.53am. One officer brought a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) and applied it to the man. The defibrillator advised that resuscitation should continue. The nurse arrived at the cell at 1.56am and joined the prison officers in the resuscitation attempts. She inserted an airway into the man's throat and gave oxygen. The manager asked for the defibrillator from B wing to ensure that there had been no malfunction with the one they had first used, but the second machine also did not indicate that a shock should be given. They applied the defibrillator twice more and each time it advised resuscitation.

61. An ambulance arrived at Whitemoor at 1.59am and paramedics reached the cell at 2.08am and took over from the prison staff. They asked the SO to check the cell for drugs but he did not find any. At approximately 2.35am, they registered a pulse. They continued attempts to try to revive the man but, at 2.50am, his pulse stopped. After further resuscitation attempts, the paramedic pronounced him the man dead at 3.04am.

**Debrief**

62. The deputy governor held a debrief with the staff involved in the emergency response to discuss any issues arising and offer support. A nurse was not able to attend but had a separate debrief with the deputy governor.

**Liaison with the man's family**

63. The man's listed next of kin was his partner. In view of the distance between her home and the prison, Whitemoor staff contacted HM Prison Full Sutton and one of their family liaison officers informed her in person of the man's death that day. One of Whitemoor's custodial managers was appointed family liaison officer and she and another prison officer visited the man's partner on 12 September.

64. Very sadly, in October 2013, the man's partner took her own life. As the family liaison officer had also been in contact with the man's sister, she then liaised with her as next of kin. The prison contributed to the cost of the man's funeral, in line with national guidance.

**Informing prisoners**

65. Notices were posted to prisoners and staff informing them of the man's death. Prison staff told the man's close friends individually. They also reviewed all prisoners who were being monitored as a risk of suicide and self-harm in case

they had been adversely affected by the man's death and offered support for any prisoner who felt that he needed it.

**Post-mortem**

66. A post-mortem examination showed that the man died as a result of hanging. The toxicology report showed that in addition to the drugs consistent with the medication he was taking, there was a concentration of 138 milligrams of alcohol per decilitre of blood in the man's system. (The legal limit for driving is 80 milligrams per decilitre.) This is a level which would cause moderate drunkenness in a normal social drinker, with effects such as disinhibitation, confusion and loss of judgement.

## ISSUES

### Clinical care

68. The clinical reviewer reviewed the man's care since his imprisonment in 2011. He found that certain aspects of the man healthcare fell below that he could have expected in the community and makes a number of recommendations. We comment on those issues directly relevant to the man's death, but the Head of Healthcare will need to address the other issues raised in the clinical review relevant to Whitemoor.

69. The man had a significant level of contact with the prison's mental health team, particularly after his suicide attempt in September 2012. The clinical reviewer notes that the mental health in-reach team use a different computer record system to the primary care team. Although some information had been copied across, it is not routinely shared between the systems and teams. For example, information obtained by the in-reach team from external agencies and the man's care programme approach (CPA) care plan were not included in his medical record. It is important that healthcare staff are aware of all relevant aspects of a prisoner's care. The clinical reviewer recommends that all CPA documents from the in-reach team should be scanned onto the primary care records. We agree and make the following recommendation.

    **The Head of Healthcare should ensure that all healthcare staff have access to relevant medical information about a prisoner.**

70. Nevertheless, the clinical reviewer considers that the standard of mental healthcare the man received exceeded that which he could have expected in the community. He describes the care the man received from the mental health in-reach team after his suicide attempt, in September 2012, as excellent and notes that the man's care plan under the CPA programme was regularly reviewed.

### The man's risk of suicide and self-harm

71. After the ACCT was closed in November 2012, following his suicide attempt in September 2012, there was little to indicate that the man was at further risk, although the crisis plan in his care plan in March 2013 indicated that this was considered a possibility. The investigator spoke to the prisoner in the next cell to the man who said that as far as he was aware, the man was not suffering from any prison-related problems. He was not being bullied, was not in debt and had no problems on the wing. The man's personal officer said that the man had been pleased to gain enhanced regime status. He had enjoyed using his PlayStation and planning which games he was going to buy. None of the other prisoners with whom he regularly played games noticed anything to indicate that he had any problems in the time leading up to his death. The man was worried about his dental treatment but there appears to have been nothing to indicate that the man was at risk or suicide in the weeks leading up to his death.

72. Security staff monitored the man's conversation with his partner on 8 September, at random. When they heard his partner end their relationship,

they reported this to staff on the man's wing. Recognising the potential implication and passing the information on so quickly, particularly on a Sunday afternoon when there are fewer staff on duty, was astute and reflects a genuine and good level of care and awareness of risk.

73. Wing staff spoke to the man and reported it to the wing manager. Although the man did not display any signs of distress and said that he was all right, the custodial manager was aware of his previous suicide attempt and decided to open an ACCT plan. We consider this was the right thing to do and showed proper consideration for the man's safety and wellbeing.

74. The investigator asked the custodial manager about the level of observations and support he put in place as part of the ACCT immediate action plan. The custodial manager said that he had been mindful of the man's previous suicide attempt and considered whether the man needed constant supervision or to be moved to a safer cell (which are designed with minimal ligature points). He decided that the man's level of risk at the time did not make this necessary. Staff said that he was behaving normally and he had said he was okay. He was playing his PlayStation, something that he did frequently and enjoyed. The custodial manager was aware that moving him to a different cell would remove the man from his possessions, which were potentially a source of support. The level of risk that he appeared to present did not, in the custodial manager's opinion, warrant a move to a safer cell or to suggest he needed constant supervision. As the custodial manager was unaware of the crisis plan in the man's CPA care plan, we consider his decisions about the level of support and observations were reasonable in the circumstances and there was nothing at the time to suggest that his risk was so high that items such as shoelaces needed to be removed from his cell.

**Sharing/management of the man's crisis plan**

75. The man's crisis plan, recorded in his CPA in March 2013, says that, "should he express any distress to the wing staff, he should be placed in a gated cell on constant watch to maintain his safety". Neither the CPA, nor the crisis plan was shared with the primary care team so this information was not noted in the man's general medical record. Wing staff were not informed of the crisis plan so were unaware of the mental health in-reach team's expectation. The man told one officer that he had a crisis plan which said he should not be left alone in his cell during work periods but there was no formal communication of the plan. When the ACCT was opened, none of the staff involved were aware of the plan that he should be put in a gated cell and constantly observed if he should express distress.

76. The man's psychologist and his community psychiatric nurse both said if the situation had arisen while mental health staff were on duty and they had been made aware of it, the crisis plan would have led to the man being put into a gated cell under constant supervision. The clinical reviewer believes that if staff in the in-reach team had been aware that an ACCT had been opened or if wing staff knew the details of the crisis plan, the man's death could have been prevented.

77. We have considered the instruction in the crisis plan, which states that the man should be subject to constant supervision if he showed or expressed any

distress. On 8 September, he did not indicate that he was distressed, but staff decided to start ACCT monitoring as a precaution after the apparent breakdown of his relationship. Nevertheless, we agree with the clinical reviewer that Whitemoor should take steps to make crisis plans created by the mental health team available to primary care and wing officers. We do not consider that there were any issues of medical confidentiality which would have inhibited sharing the information in the man's crisis plan. There seems to have been little point to the plan if it was not shared. It is important that information that might affect a prisoner's safety is available to all the necessary staff, even if it is only an instruction to refer them immediately to healthcare staff where there are matters of medical confidentiality. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all relevant staff are made aware of any crisis plans for managing prisoners assessed as a risk of suicide and self-harm.**

**Emergency response**

78. When the officer returned to the cell just before 1.50am, he was concerned about the man but was unable to see him properly. He called for assistance, but did not go into the cell even when another officer arrived. Both officers waited until the night orderly officer and his deputy arrived shortly afterwards. .

79. Usually cells should not be opened at night but officers carry a key in a sealed pouch for use in an emergency. National instructions in PSI 24/2011 say that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff may enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger and should first make every effort to get a verbal response from the prisoner. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment of the situation. . .

80. The officer decided not to go into the cell. He told the investigator that he was unsure of the risk and was not sure that the man's failure to respond was a definitive sign that there was a problem. Although he said he had considered going in he said "we are instructed to wait for help or wait for other officers to turn up". As the officer had called an emergency code blue he had already assessed the situation as life threatening. He knew the man and knew he had made a serious attempt to kill himself by hanging before. He had previously been the man's personal officer and described him as "never a problem, he was never an issue. [he was] polite, friendly, appropriate all the time; the ideal prisoner."

81. While we understand that it is difficult for officers in such situations to make decisions quickly, we are surprised that with his knowledge of the man, the officer did not go into the cell when it appeared that the man might be hanging, even when a second officer came along. Nevertheless, the officer concluded there was a degree of risk. While we cannot know whether earlier entry into the cell would have changed the outcome in the man's case, in such an

emergency every second could be crucial. We are concerned that staff at Whitemoor seemed to be under the impression that it is necessary to wait for the orderly officer to attend before going into the cell. We make the following recommendation.

**The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life and that local policies and instructions reflect this prominently.**

82. When he called the code blue emergency, the officer did not use his radio but used the telephone in the wing office. He explained to the investigator that he panicked, but realised in retrospect that he should have used the radio. The wing office was not far from the man's cell and we are satisfied that there was little delay. The control room immediately issued a code blue indicating a prisoner who is unconscious or has breathing difficulties and other staff arrived quickly.

83. Although the control room staff put the emergency code blue call across the radio network when they received the officer's telephone call, they did not, request an ambulance until asked to do so at 1.53am. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies and that an ambulance should be requested automatically and immediately as soon as an emergency code is called.

84. Whitemoor had no protocol for staff reflecting the guidance in the PSI at the time of the man's death. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Whitemoor has a Medical Emergency Response Code protocol which:**

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

85. The clinical reviewer considered that the response when staff found the man hanging was carried out effectively. Staff had been properly trained to use CPR and also used a second defibrillator to be sure that the first did not have a fault.

**Alcohol in the man's system**

86. The post-mortem examination found that the man's system contained a level of alcohol that would have caused moderate drunkenness in a normal social drinker. The Coroner's office said that there was no information to suggest that the levels in the man's blood were attributable to post-mortem changes or anything other than the consumption of alcohol.

87. In November 2012, prison staff had challenged the man about involvement in drinking hooch, but he had denied this. As a category B prisoner, the man's cell was searched every three months. It had not been searched the day that he died. However, all cells are subject to daily fabric checks and staff should be alert to any odours that suggested alcohol. Nothing untoward was reported that day and when the man's cell was cleared after he died, there was no evidence of any alcohol. Whitemoor's security department confirm that there were no security reports relating to fermenting liquid in September. We have found no evidence to account for how or when the man obtained alcohol and whether this had played any part in his death.

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that all healthcare staff have access to relevant medical information about a prisoner.

2. The Governor and Head of Healthcare should ensure that all relevant staff are made aware of any crisis plans for managing prisoners assessed as a risk of suicide and self-harm.

3. The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life and that local policies and instructions reflect this prominently.

4. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Whitemoor has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff called to the scene bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances

ACTION PLAN

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion | Progress (to be updated after 6 months) |
|---|---|---|---|---|---|
| 1 | The Head of Healthcare should ensure that all healthcare staff have access to relevant medical information about a prisoner. | Accepted | The Head of Healthcare will ensure via partnership working with the Mental Health In-reach team that healthcare staff have access to relevant medical information about a prisoner and this is clearly documented on the Clinical IT records - System One. MH In-Reach have full access to System One. | May 30th 2014 | |
| 2 | The Governor and Head of Healthcare should ensure that all relevant staff are made aware of any crisis plans for managing prisoners assessed as a risk of suicide and self-harm. | Accepted | All prisoners having an ACCT closed will have a Risk Support Form completed by the review team. Prisoners' consent will be sought if this needs to involve anything confidential. The form will include any ongoing risks and triggers related to potential self-harm. This form will be placed in a folder kept in the Centre office of all residential areas and in the Oscar's office & Safer Prisons Office.<br>This folder can be accessed by any member of staff - including officers, Healthcare, Inclusion, In-reach, Chaplaincy etc in the event of new self-harm or welfare concerns emerging, whether during normal hours or out-of-hours.<br>The list of prisoners new onto the Risk Support Form will be on the Daily briefing Sheet<br>This list will be reviewed at the monthly Safer Custody meeting. | May 30th 2014 | |

| | | | | | |
|---|---|---|---|---|---|
| **3** | The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Whitemoor has a Medical Emergency Response Code protocol which:<br><br>a)Provides guidance to staff on efficiently communicating the nature of a medical emergency;<br><br>b)Ensures staff called to the scene bring the relevant equipment; and<br><br>c) Ensures there are no delays in calling, directing or discharging ambulances. | Accepted<br><br>Accepted<br><br>Accepted<br><br>Accepted | The Contingency Plan for Medical Emergency Response – Codes Red and Blue based on PSI 03/2013 was devised by the Head of Healthcare and Head of Residence in March 2013. This was then published to all staff. The Head of Safer Custody will ensure that this is re-issued.<br><br>An existing process is already in place using code blue (breathing issues) code red (bleeding issues). Used as the emergency response via radio , telephone or emergency telephone this is broadcasted and the medical staff attend in response<br><br>With the code blue or red response medical staff respond with all the appropriate equipment<br><br>Medical responses are in place and the ambulance is requested via the control room. | May 30th 2014<br><br>April 2014<br><br>April 2014<br><br>April 2014 | |