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 2014, a prisoner at HMP Leicester

Our Vision

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

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Leicester on 29 August 2014 and died in September. He was 21 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was undertaken. The prison cooperated fully with this investigation. My investigation was suspended at the request of Leicestershire police until they completed their enquiries. I am sorry for the consequent delay in issuing this report.

This is an extremely sad story. The man had not been in prison before. He was a vulnerable young man under the care of community mental health services. From the time he arrived at the prison, staff identified his risk and managed him under Prison Service suicide and self-harm prevention procedures. However, he assaulted an officer and he was moved to the segregation unit. He hardly spoke to anyone and only rarely left his cell. He received no visits and made no phone calls. The prison mental health team referred him for a possible transfer to a psychiatric inpatient unit, but he was assessed as unsuitable.

The segregation unit of a busy and crowded local prison is no place for a vulnerable young man with mental health problems like his, and should be used only in exceptional circumstances for those at risk of suicide and self-harm. While I have considerable sympathy for the prison, whose options were very limited, his location significantly compromised the ability of staff to form meaningful relationships with him and provide the support he needed. The investigation also identified that segregation unit checks did not take place as expected, suicide and self-harm prevention procedures did not always operate effectively to protect him and there was a need for better information sharing in the mental health team.

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 **July 2015**

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SUMMARY

1. In September 2013, the man was admitted to a mental health unit after taking an overdose of co-codamol. He was diagnosed with moderate depression with psychotic symptoms and discharged in October 2013. In December 2013, he was allocated a community psychiatric nurse. His mental state improved with anti-depressants but he stopped taking his medication in early 2014. His mental state deteriorated, possibly because of taking new psychoactive substances.

2. In July 2014, the man went to his local hospital because he felt suicidal. Mental health services considered he was feigning psychosis. On 27 July, he was cautioned for behaving threateningly and, on 29 July, he randomly attacked a cyclist in the street. On 30 July, court mental health services decided he was not suitable for a psychiatric inpatient unit and he was remanded to HMP Leicester. It was his first time in prison.

3. A reception nurse was concerned about the man and began Prison Service suicide and self-harm prevention procedures (known as ACCT). The next morning he headbutted an officer and was moved to the segregation unit. On 2 August, he was placed on a basic regime

4. The man rarely responded to staff when they tried to talk to him and was locked in his cell for most of the time. He tried to attack officers or rush the door several times when officers opened it. He took no active part in the ACCT process and often just stared in response to attempts to engage him.

5. A member of the mental health team visited the man daily and he took antidepressant and antipsychotic medication. Two prison psychiatrists diagnosed psychosis and referred him to a psychiatric inpatient unit. A psychiatrist from the unit assessed him on 21 August, but concluded he was not suitable for admission and his behaviour appeared to be the result of heavy substance misuse.

6. On the evening of 29 August, staff found the man hanged in his cell. Prison staff and paramedics gave him cardiopulmonary resuscitation for 30 minutes and managed to find a heartbeat. Paramedics took him to hospital, but he died in September, without regaining consciousness.

7. Vulnerable, mentally ill prisoners at risk of suicide and self-harm should only be segregated in exceptional circumstances. While we have sympathy with the prison whose options were very limited, the man's location significantly compromised the ability of staff to form meaningful relationships with him and give him support he needed. The reasons behind his continued segregation were not sufficiently well documented and we would like to have seen more evidence that other options were considered fully.

8. Our investigation raises concerns about segregation unit checks, aspects of the ACCT process and information sharing in the mental health team. We make four recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices about the investigation to staff and prisoners at HMP Leicester inviting anyone with information to contact her. No one responded.

10. The investigator obtained relevant documents about the man's time in prison. She interviewed members of staff and a prisoner who had lived in one of the cells next to him. The prisoner in the cell the other side did not want to be interviewed. She also spoke to a member of the Independent Monitoring Board and the man's community psychiatric nurse. She informed the prison about the initial findings of the investigation.

11. A clinical reviewer reviewed the man's clinical care at Leicester on behalf of NHS England, East Midlands Region.

12. We informed HM Coroner for Leicester City and South Leicestershire of the investigation and have sent her a copy of this report.

13. One of our family liaison officers informed the man's uncle about the investigation. He asked whether his nephew's mental health had been managed appropriately and if there had been continuity of care between his treatment in the community and his treatment in prison. He questioned the decision to close the ACCT on the day he hanged himself. He said he thought his nephew should have been in hospital not prison.

14. The man's uncle and niece received a copy of the draft report. The solicitor representing them wrote to us raising two issues that do not impact on the factual accuracy of this report. We have responded by way of separate correspondence to the solicitor.

HMP LEICESTER

15. HMP Leicester is a local prison that holds nearly 400 men. The prison primarily serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Leicestershire Partnership NHS Trust provides healthcare services at the prison.

Her Majesty's Inspectorate of Prisons

16. HM Inspectorate of Prisons (HMIP) last inspected Leicester in November 2013. Inspectors found that the prison was unacceptably overcrowded, though good staff-prisoner relationships offset some weaknesses in safety and credible work was underway to address areas where improvement was needed. One of these was healthcare – the previous service provided by SERCO had deteriorated badly at the end of their contract. Leicestershire Partnership Trust was beginning to address these failings but significant further improvement was needed.

17. The quality of ACCT (suicide and self-harm prevention procedures) documents was mixed, but better on the smaller units. Staff demonstrated good knowledge of prisoners at risk, but some staff said they felt removed from the process now that custodial managers were responsible for assessments, reviews and post-closure interviews.

18. Care and support in the segregation unit had improved. There were formal plans for each segregated prisoner and staff made useful entries in prisoner records.

19. There were effective working relationships between the prison and mental health staff. Almost half the prison officers had received mental health awareness training. The new mental health lead was developing monitoring systems and clear clinical pathways.

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 2013/2014 annual report, the IMB noted that the segregation unit did not have sufficient capacity. The relatively long-term occupation of the unit by prisoners with complex mental health problems exacerbated this issue. The IMB praised the efforts of segregation unit staff to care for these prisoners.

Previous deaths

21. The man was the first self-inflicted death at Leicester since June 2011.

Assessment, Care in Custody and Teamwork (ACCT)

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

KEY EVENTS

23. In September 2013, the man was assessed at the Place of Safety Assessment Unit in a hospital. It was his first involvement with mental health services. He said he had attempted to kill himself twice, once by overdose of co-codamol and once by hanging. On 6 September 2013, he was admitted to Ashby Ward of the Bradgate Mental Health Unit, part of another hospital. Doctors diagnosed moderate depression with psychotic features and treated him with venlafaxine (an antidepressant) and diazepam (for anxiety).

24. The man was discharged from the Bradgate Unit on 30 October 2013. He did not go to a planned psychological assessment at the Francis Dixon Lodge (a specialist unit in Leicester for people with personality disorders) and missed two further outpatient appointments there. He was assigned a community psychiatric nurse in December 2013. The nurse described the man's home life as "quite chaotic". His father had murdered his mother when he was a baby. He said the man suffered from depression.

25. The psychiatric nurse saw the man every two weeks. He said the man initially responded well to antidepressants and his mental state stabilised. He had a limited social circle and the nurse tried to involve him with the social inclusion team but he was not interested. The nurse said he was not an easy person to help. In July 2014, he referred him to a psychologist, after he disclosed he had been seriously sexually abused as a child.

26. The psychiatric nurse said he did not think the man was a serious risk of suicide. He said, although the man was technically at risk, because he had attempted suicide in the past, he thought that he had moved on since his stay in the Bradgate Unit. At a review in April 2014, he admitted to some suicidal thoughts but said he had no plans to carry them out. The nurse said the man was planning to work in the video games industry.

27. The psychiatric nurse last visited the man on 8 July 2014. He said the man increasingly used new psychoactive substances, synthetic cannabinoids, such as Mamba or Spice. On this occasion, he had recently used Mamba and appeared paranoid. He told the nurse he had stopped taking his medication some months previously.

28. The psychiatric nurse went on holiday later in July and, while he was away, the man went to the Accident and Emergency department of his local hospital more than once, because he felt depressed and suicidal. The crisis response and home treatment team (CRHT) assessed him and thought he was pretending to be psychotic in order to return to the Bradgate Unit. On 27 July, the police cautioned him for behaving threateningly to a member of the public. This was his first involvement with the police.

29. On 29 July, the man was arrested and charged with assault occasioning actual bodily harm. According to witnesses, he kicked a passing cyclist in the face and asked him to fight him. He did not know the victim. A member of the public detained him until police arrived. He spent the night in police custody

and appeared at court the next day. The criminal justice team (part of the mental health crisis team that work at court) decided he was not suitable to be detained in a psychiatric inpatient unit and he was remanded into custody. It was his first time in prison and there is no record that he had ever behaved violently before.

30. A prison substance misuse worker was on duty in reception when the man arrived at HMP Leicester at about 6.00pm on 30 July. She told the investigator his behaviour concerned her immediately. He appeared spaced out and "not there". He was muttering as if he was talking to someone and was standing straight and hardly moving. She discussed him with her colleague. She said it was hard to tell if he was mentally ill or whether his behaviour was drug related. His general appearance suggested mental illness to her. She and her colleague determined from him that he had not consumed alcohol or opiates. He told them he had taken Mamba. He said he wanted to work with substance misuse services. She told him she would come and see him the next morning.

31. At an initial health assessment, a nurse described the man as unkempt, smiling and laughing to himself and apparently under the influence of drugs. He told the nurse about his community mental health treatment and that he had attempted to take an overdose in the past but was vague about current thoughts of suicide and self-harm. The nurse referred him for an urgent mental health assessment and began ACCT procedures.

32. A locum agency mental health nurse recognised the man's name when the previous nurse told him a new prisoner was behaving strangely. The nurse had assessed him in the Place of Safety Assessment Unit in September 2013. He recognised the nurse and was happy to speak to him. The nurse thought he was withdrawing from drugs and was shocked by his appearance. He remembered him as neat, clean and tidy, but now he was unkempt and dirty.

33. A custodial manager completed an immediate action plan and decided that staff should check the man four times every hour at irregular intervals until he had an ACCT assessment. He had been assessed as high risk to others if he shared a cell and she said his cell sharing risk assessment should be reviewed the next day. She noted that the mental health team needed to assess him.

34. At 8.15am on 31 July, the substance misuse worker went to see the man as promised. She said he was not in the right frame of mind for an assessment, so she had suggested that they sit down and talk instead. They sat on the wing but he got up and walked around the pool table muttering to himself. She said she made a note in his ACCT document and told the staff she was concerned he was mentally ill. She mentioned her concerns about him at a healthcare multidisciplinary team meeting that morning. She said she did not think that his behaviour related to drug or alcohol issues. The multidisciplinary team decided to wait for the outcome of a mental health assessment, which had been requested.

35. At about 8.55am, the man headbutted an officer who asked him if he wanted to go out to the exercise yard for some time in the open air. A Supervising Officer (SO) took him to the segregation unit. Staff walked him there but did not use handcuffs or otherwise restrain him. The SO noted on his prison record that he repeatedly mumbled that he knew staff were going to kill him. Because of his unpredictable risk of violence, an operational manager decided that three members of staff should be present when they opened his cell, (known as 'three-man unlock').

36. That morning, the mental health nurse asked the community psychiatric nurse to fax the man's community psychiatric notes to the prison. These arrived the same day and were scanned into his prison medical record. After talking to the psychiatric nurse, the mental health nurse asked the GP to prescribe the same antidepressant the man had been prescribed in the community. The GP thought a psychiatrist should review him first. The psychiatrist was in the prison that afternoon and the mental health nurse re-arranged his appointments so that the psychiatrist could see the man. By this time, he had been taken to the segregation unit.

37. At noon, an officer tried to assess the man as part of the ACCT procedures, but he did not respond to any of her questions. A custodial manager and the officer held the first ACCT case review with him at 1.50pm. No healthcare staff were present. The manager wrote that the man behaved in a bizarre manner and was mumbling unintelligibly. He noted he was unable to assess the man's risk properly but marked it as raised. The review concluded that he required support from the mental health team. The manager did not enter any actions on the ACCT caremap.

38. A further ACCT review took place at 3.20pm with several staff. The man would not answer the psychiatrist's questions. The review concluded that his risk of suicide and self-harm was low, but officers should continue to check him four times every hour. The staff decided that he should remain in the segregation unit because of his violent behaviour. They added no actions to the ACCT caremap.

39. The mental health nurse completed an initial segregation health screen. He told the investigator that putting anyone in the segregation unit required careful consideration. He said he agreed that the man could be segregated because:

- The staffing levels were higher on the segregation unit
- He would have better access to staff
- It was a smaller unit
- He would be seen daily by healthcare staff and staff from other disciplines

40. The psychiatrist updated the man's medical record. He noted that the man had seen his community psychiatric nurse regularly but had stopped taking his antidepressants six or seven months previously. He had sat quietly in the ACCT review and appeared to be in low mood. The psychiatrist prescribed

duloxetine (an antidepressant mostly prescribed for major depressive disorder) and quetiapine (an antipsychotic that can be used in conjunction with an antidepressant to treat major depressive disorder). He said mental health nurses should continue to assess the man's mental state and the effects of the medication.

41. On 1 August, an operational manager signed the form authorising the man's segregation for an initial period of 72 hours. She gave the reason for segregation as his assault on the officer, his strange behaviour and his refusal to engage with staff. She noted that he was due to see a psychiatrist and was a patient of the mental health team. She did not give any exceptional reasons why he should be segregated as someone on an ACCT and did not write anything in the ACCT record. A nurse completed a segregation health screen and indicated that, although he was on an open ACCT, the psychiatrist was content for him to be segregated.

42. The mental health nurse saw the man on 1 August, during a daily segregation unit check. He said the man did not really converse but answered straightforward questions, which was a marked improvement from the day before. An officer wrote on the man's prison record that he had accepted his meals but when staff spoke to him, he just stared at them. He spent the day either lying under or on his bed and staring at the ceiling or laughing loudly. Sometimes he stared through the observation panel if staff spoke to him and either made a fist or made faces. A prison chaplain tried to explain the purpose of daily chaplaincy visits in the segregation unit, but the man looked briefly at him before turning away. When officers opened his door for him to receive his evening medication, they noted that he mumbled to himself and approached them in an aggressive manner.

43. On 2 August, the man set fire to toilet paper in his cell. When officers put out the fire, he stood on the bed and tried to jump on them. They restrained him and removed the bedding and lighters from his cell. An agency nurse examined him and he told her he was unhurt. The same nurse checked him later and was able to have a conversation with him but he would not say why he had set the fire.

44. Later the same day the man was put on basic level of the incentives and earned privileges scheme (IEPS), because of his behaviour. An officer told the investigator that, at first, the man tried to rush the door every time officers opened his cell. Although he began to do this is less frequently, his behaviour remained volatile and unpredictable.

45. On 3 August, a nurse attempted to assess the man. She said officers told her that he needed three staff to open his door because he was violent and unpredictable. They told her they would not open his cell because he might refuse to go back in or try to fight. She said she shouted to him through the observation panel in his door, but he did not respond, making the assessment impossible. She said that he made minimal eye contact, used signs to communicate and appeared to be responding to unseen stimuli. She described him as "lost and wandering" in his cell. She recorded that officers

told her that he did not talk to anyone and ate his food very fast “like an animal”.

46. On 4 August, a custodial manager and an officer tried to hold an ACCT review with the man but he refused to speak. The officer discussed her visit to him with the clinical mental health manager. They agreed that the visiting psychiatrist should review him and mental health nurses should monitor him closely. The mental health nurse contacted the Bradgate Unit and asked for his records.

47. The Head of Security held a segregation review board on his own. He authorised the man’s continued segregation because he had assaulted a member of staff and was behaving bizarrely. He said his decision should be reviewed the following day. A nurse (signature illegible) completed a segregation health screen. The nurse indicated that he was on an ACCT. She ticked no in answer to the question about whether he was psychotic.

48. The Head of Security, Head of Safer Custody, a mental health nurse and a member of the Independent Monitoring Board attended a segregation review board on 5 August. The man was not present. The review board noted that he was behaving strangely, frequently became aggressive when officers opened his cell and was not talking. The section on specific concerns about mental health and risk of suicide and self-harm noted that he was on an open ACCT and was due for further mental health assessment.

49. The review board decided he should remain segregated and reviewed again on 19 August. The Head of Safer Custody wrote on the man’s segregation unit care plan that staff were concerned he would not be safe on a normal wing. The mental health nurse completed another segregation health screen. She ticked no to all the questions, including ‘is the prisoner on an open ACCT’. The record of the review does not indicate that the staff considered whether there were exceptional circumstances to justify his continued segregation, which is a requirement for a prisoner subject to ACCT monitoring. No entry was made on his ACCT and the staff did not hold an ACCT review.

50. The psychiatrist reviewed the man on 7 August and recorded that he remained unpredictable and unwell. He appeared to be eating and drinking and taking his medication. His eye contact was poor and his speech was monotonous and quiet. He was guarded and kept looking round suspiciously. The psychiatrist thought that he was suffering depression with psychotic features. He changed his medication to sertraline (an antidepressant), olanzapine (an antipsychotic) and lorazepam (a benzodiazepine used to treat anxiety). A mental health nurse saw him on 8 August but there was no change to his presentation. She was not sure whether he took his medication as he first spat it out but then put some back in his mouth after she encouraged him.

51. On 9 August, an officer reported that the man had tried to attack staff twice that day. He said he seemed perpetually confused and aggressive. A

custodial manager held an ACCT review, but no other member of staff was present and the man did not attend. The manager said the man did not seem interested in participating in the ACCT process and he could therefore see no reason to keep the document open. He closed the ACCT. He told the investigator that he had not discussed his decision with anyone else but was aware that the man was a patient of the mental health team and, between them and the hourly segregation unit checks, he considered that the man would continue to receive support.

52. On 10 August, an officer spoke to the man about his aspirations to become a video games journalist. This was the first time he had had a normal conversation with an officer. The officer told the investigator that the man often stood inside his cell at his door and staff had spent some time trying to get him to talk to them. Sometimes he growled at officers but usually he just stared blankly. On this day, the officer said he had seemed upset and asked him whether he would be able to get back to normal and do the things he usually did outside prison. He had then spoken about video games, journalism and his plans. The officer said he asked him several questions about gaming and he responded normally. The officer said he had tried to reassure him that he would not be in prison forever.

53. On 12 August, staff noticed two torn lengths of sheet in the man's cell. A manager told the investigator that the man was lying under his bed at the time. He then passed the torn sheet under the door to her colleague when she asked. She opened his ACCT again and held a review with him and two officers. He would not say what he had intended to do with the pieces of sheet. She recorded his risk as raised and said he should be checked four times every hour.

54. A psychiatrist saw the man that afternoon. He and a mental health nurse spoke to him in the adjudication room with four officers present. The nurse said he was responding to hallucinations. He became verbally aggressive and officers took him back to his cell. The psychiatrist diagnosed a psychotic disorder. He stopped his sertraline and increased his olanzapine from five to 15mg. The psychiatrist said he would review him in two weeks to adjust the dose of antipsychotic medication. The next day, 13 August, the nurse booked an appointment for a consultant psychiatrist from a hospital to assess him for suitability to transfer to a psychiatric inpatient unit.

55. A psychiatrist saw the man on 14 August. He said the man was guarded and uncooperative. He mumbled in a very quiet monotonous voice. He thought the man was having an acute psychotic episode. He re-prescribed sertraline and increased his olanzapine to 20mg. A mental health nurse told the man's solicitor and the court listings department that he was not fit to attend court the next day, because he was too mentally ill.

56. On 15 August, a manager held an ACCT review, which a mental health nurse attended. The man would not respond and she noted that he had been unfit to attend court that morning. She assessed his risk of suicide and self-harm as low and reduced his checks to twice an hour. She set a caremap action

that he should take his new medication regularly. The same day, he handed staff a pointed weapon made from a broken pencil, tin foil and cotton. He agreed to come out of his cell to have a shower.

57. On 16 August, a mental health nurse spoke to the man through his observation panel. He said that his speech was normal and he made good eye contact. He said he would like to go back to his flat. The nurse explained that this would be a decision for the court. They discussed his risk to staff and he told the nurse he felt calmer. The nurse told the investigator that the man looked much better than when he had first arrived. The nurse thought he was building a rapport with the manager and an officer.

58. An hour after the mental health nurse's visit, an officer reported that the man was pacing in his cell. He growled at her, banged his door, wailed and made a stabbing motion towards her when she tried to talk to him.

59. On 18 August, a mental health nurse assessed the man as unfit to appear by video link at a court hearing. She noted he was "wailing" with his head in his hands. He appeared disorientated and said he was in a trap and could not get out. She booked an appointment for him to see the psychiatrist the next day.

60. On 19 August, staff held the scheduled segregation review board. The review board concluded that the man should remain in segregation because he became aggressive when his door was opened, his behaviour remained unpredictable and strange and he had made weapons. There was no reference to him being on an ACCT and the review did not consider whether any alternative location would be more appropriate. They did not hold an ACCT review.

61. A psychiatrist saw the man that afternoon and noted he appeared anxious and without insight. The psychiatrist diagnosed a psychotic disorder and suggested splitting his olanzapine dose during the day. He completed another segregation health screen. He indicated the man was waiting for an assessment to transfer to a secure NHS bed and ticked both yes and no to the question about whether he could cope with a period of segregation.

62. On 21 August, a consultant psychiatrist assessed the man in the segregation unit with a mental heal nurse present. His assessment was scanned into the man's medical record on 1 September. He said the interview had been difficult to conduct because the man had been reluctant to talk. He said the man showed mild to moderate symptoms of depression without recurrent thoughts of death or suicide. He reported hearing voices but the psychiatrist saw no evidence of formal thought disorder. The psychiatrist said the man had become calmer and quieter since taking medication, an improvement noted by the prison in-reach team. At the time of the assessment, he did not think the man posed an imminent risk to himself or others and his earlier behaviour appeared to have been a result of heavy substance misuse. He concluded that the man was not suitable for admission to a psychiatric inpatient unit.

63. On 22 August, a custodial manager chaired an ACCT review with a nurse and two officers. He said it was difficult to communicate with the man because he took minimal part in the discussion. The man said he felt paranoid and could hear voices. He was unable to articulate his feelings about self-harm. He became increasingly agitated and officers took him back to his cell. The review assessed his risk as low and reduced his observations to one an hour with three recorded conversations daily. The manager wrote on the caremap that officers should encourage him to take his medication because there was some doubt that he was taking it regularly. He did not add any new actions.

64. On 23 August, officers gave the man a radio. The next day, he told a manager that it did not work and she found that he had not plugged it in. She tuned it for him and said he appeared to enjoy listening to it. She said officers had given him a magazine but no one saw him read it. He appeared to enjoy making boats and islands from the foil trays his food came in. (Officers told the investigator that he had originally had a radio but had damaged it. There is no record of this.)

65. The man's ACCT record shows he was now generally much calmer when officers unlocked his door to give him his food and medication. Several entries note that he appeared very sleepy. Sometimes he did not take his medication, as he did not get out of bed. On 25 August, he began to cry and tried to leave his cell when officers unlocked the door. They coaxed him back to his bed and gave him his medication. He then tried to get out of the cell again. The officer left and he kicked the door. Later officers noted he sitting rocking on his bed. He would not talk to a GP when he did a daily round.

66. The next day, the man told an officer that he did not want to take his medication because it only made him feel better for a while. During the night of 26/27 August, he put his mattress under the bed and slept there for an hour and a half.

67. On 28 August, a mental health nurse discussed the man's location with the prison's Head of Safer Custody. She said that she understood that the mental health in-reach team had hoped that he would transfer to a psychiatric inpatient unit but this avenue had now closed. All segregated prisoners in Leicester should have an exit plan if they spend 30 days in segregation and she decided it was a priority to try to move him from the segregation unit.

68. The Head of Safer Custody said she understood the man had started to respond to the medication and had begun to leave his cell and participate in a limited way with the regime. However, his location in the segregation unit meant that it was very difficult for staff to engage with him. She considered that the only alternative was to move him to the substance misuse landing, where there was a higher concentration of healthcare staff than on other wings and it was easier to observe prisoners as the hatches in the door were bigger. She said she needed first to discuss the practicalities of this plan but intended to try to move him on Monday, 1 September.

69. A mental health nurse spoke to the man between 10.00 and 10.30am. She said she had a normal conversation with him. He asked her how he could move on and she advised him to cooperate with the officers and establish some trust. She told him to let officers know about his concerns as they arose. He had a shower after her visit.

70. At 10.50am, a manager and a mental health nurse held an ACCT review, but the man refused to attend. The manager told the investigator that the man had appeared to improve that week. He had made no attempt at suicide or self-harm since he had arrived at the prison. He had started to spend some time out of his cell and his medication seemed to be working. She said there had been some talk about moving him from the segregation unit but there was no firm plan. She did not think that he was gaining anything by being managed under ACCT procedures, especially as all segregation unit prisoners were checked hourly and visited daily by healthcare and other staff. She and the nurse agreed to close his ACCT. Although this was not reflected on the ACCT record, she told the investigator that she had discussed the decision with several other members of staff and had thought hard about the decision.

71. Two officers were on duty in the segregation unit that afternoon. A prisoner in the cell next to the man broke the glass in his observation panel and set two fires during the afternoon. Officers also suspected he had made weapons. Officer A put out the fires by putting a hose through an inundation point in the cell door and called the fire brigade both times. Officer B said that the prisoner had occupied their attention for most of the day. This meant that they had not had time to allow any of the other prisoners out of their cells for time in the open air or a shower that day. Officer A recorded on the man's daily segregation history sheet that he had checked him at 4.30pm, but CCTV coverage from 4.00pm shows that no one checked him at this time.

72. Prisoners in the segregation unit usually have their dinner between 4.30 and 5.30pm. The meals are brought to the unit and given to the prisoners in their cells. Officer B said there were four prisoners in the unit who were supposed to have more than two officers present when their cells were opened. Both officers decided to give the other prisoners their meals first, but agreed that, if the man was in bed, they would open his door and leave his dinner inside his cell (even though there were supposed to be three officers present). Officer A said he was not worried about his risk to them, but if something went wrong, they would be questioned about why they had not waited for extra staff.

73. CCTV shows that both officers gave the prisoner in the first cell, next to the man, his meal at 4.53pm. Officer B looked into the man's cell as she passed. She told the investigator that he was sitting on his bed with his back to her. She asked him if he was okay but he did not respond. Because he was awake and sitting up they decided not to open his cell. The officers gave two more prisoners their meals. Officer B left the unit at 4.57pm because staff shortages that day meant she was needed to help serve dinner on another landing.

74. Officer A stayed in the segregation unit. He told the investigator that another prisoner in the segregation unit, who was being managed under ACCT procedures, was threatening to harm himself with some staples. He said he spent a long time talking to him and trying to get him to hand over the staples. At 5.41pm, he answered a prisoner's cell bell and spent nearly 15 minutes talking to him through the door. He returned to the unit at 6.22pm.

75. CCTV shows that the orderly officer (in charge of the routine operation of the prison that day) and an officer arrived in the segregation unit to help open cells at 6.38pm. At 6.42pm, a nurse came to give the prisoners their evening medication. Officer B arrived at 6.45pm. At 6.50pm, the staff, apart from Officer B, went to the man's cell. Officer B said she had gone to heat up the man's meal.

76. The nurse opened the cell's observation panel to tell the man it was time for his medication. He said the lights were off and it was hard to see inside, but the man looked like he was standing against the wall. The nurse asked him to get some water to take with his medication but he did not respond. The orderly officer and then Officer B looked through the observation panel. Officer B put the cell light on and saw that he was hanging. He unlocked the door and all three went into the cell.

77. The man was by the sink with a strip of sheet tied around his neck. The other end was attached to a corner of a stainless steel panel covering the toilet pipe, which he appears to have bent over. Officer B used his anti-ligature knife to cut the sheet from the pipes while the orderly officer supported his weight. The officers removed the rest of the sheet from around his neck as they lowered him to the floor. The nurse asked for an ambulance. The orderly officer began chest compressions and Officer B radioed a code blue medical emergency.

78. The nurse brought a medical emergency equipment bag from main wing and used an airway to give the man oxygen. Officer A took over chest compressions. The staff attached a defibrillator, but it advised no shock should be given. At 6.59pm, a GP arrived and examined him. She found he had no cardiac output, no pulse, was not breathing and his pupils were fixed and dilated. Paramedics arrived at the cell at 7.04pm and attached an electro-cardiogram machine.

79. The GP gave the man adrenaline and the paramedics continued cardio-pulmonary resuscitation for ten minutes (now 30 minutes in total) but his condition did not change. The GP and the paramedics agreed to stop resuscitation but within 15 seconds, his heart started beating again. They started cardiopulmonary resuscitation again. His heart stopped, paramedics gave him more adrenaline and it restarted again. The GP and the paramedics decided to take him to hospital. CCTV shows that he was taken from the segregation unit on a stretcher at 7.30pm.

80. The duty governor held a hot debrief for the staff involved in the emergency response and offered them support. He noted that dinner had been served

late because the prison was short of staff and there had been no option but to wait for sufficient staff to open some of the prisoners' cells. The GP commented that the staff who had performed cardiopulmonary resuscitation were calm and organised. The staff told the investigator that they were appropriately supported.

81. The prison contacted the man's uncle, who went to the hospital that night. He was on a life support machine in hospital and his uncle agreed that it should be turned off. He was declared dead shortly after. The prison paid appropriate funeral costs, in line with national guidance.

82. Officers reviewed all prisoners being managed under ACCT procedures in case they have been affected by the news of the man's actions. The prisoner who had been in the cell next-door, said that his observation panel had been open at the time. He had heard the emergency response and resuscitation attempts and believed that the staff had done their best to save him. He said officers spoke to him afterwards and told him about available support. He was positive about the segregation unit staff.

Post-mortem

83. A post-mortem examination found the cause of death was:

1a) cerebral anoxic brain injury
1b) Cardiac arrest
1c) Hanging by ligature

ISSUES

The decision to segregate the man

84. Prison Service Order (PSO) 1700 details the procedures to follow when segregating prisoners. A qualified healthcare professional (nurse or doctor) must complete a Segregation Safety Algorithm (health screen) for all segregated prisoners. The purpose is to make a snap shot assessment of a prisoner's mental health when deciding whether to segregate them. The safety assessment was designed in response to a European Court of Human Rights judgement in 2001, about the imposition of segregation on a mentally unwell prisoner who self-harmed. The aim is to exclude very mentally unwell, suicidal prisoners from segregation, in all but the most exceptional of circumstances.

85. In the man's case, not all the segregation health screens were properly completed. Some yes and no boxes had both been ticked in answer to the same question and some questions were answered wrongly. Some answers indicated that there were reasons not to segregate yet segregation continued. On 12 August, a psychiatrist diagnosed a psychotic disorder and, on 14 August, he was noted to be having an acute psychotic episode. He was assessed as too mentally ill to attend court during his time in the segregation unit, yet he remained there.

86. The second page of the initial segregation health screen states prisoners on an ACCT must be located in the segregation unit only in exceptional circumstances, where there is such a risk to others that no other location is suitable and when these other options have been tried or are considered inappropriate. Prison Service Instruction (PSI) 64/2011 also reinforces this and requires that "prisoners on open ACCT plans must only be located or retained in Segregation Units in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include other options that were considered but discounted". The exceptional reasons are required to be listed by the operational manager authorising the segregation on the segregation health screen and in the ACCT document.

87. On 1 August, an operational manager authorised the man's initial segregation because he had assaulted an officer, was behaving strangely and was 'refusing' to talk to staff. He did not note that the man was on an ACCT. On 5 August, another operational manager agreed segregation could continue because the man frequently became aggressive, was not talking and was waiting for further mental health assessment. On 19 August, a third operational manager authorised his continued segregation because his behaviour was unpredictable and he had made weapons but did not refer to him being on an ACCT. None of them noted the reasons as exceptional grounds to justify segregating a prisoner on an ACCT and we do not consider they were exceptional circumstances.

88. When interviewed, staff told us they did not think the man would survive on a normal wing because he was too vulnerable. Another consideration was the

higher ratio of staff to prisoners on the segregation unit and that segregated prisoners receive daily visits from nurses, chaplains, the independent monitoring board and senior managers. However, higher staff ratios and staff checks cannot be regarded as an exceptional justification for holding a prisoner in segregation, as it would apply in every case. Notwithstanding the sad outcome, his safety might have been given as an exceptional reason to segregate him but this was not mentioned as a reason on any of the documentation at the time.

89. The operational manager's original authorisation for segregation did not indicate what exceptional reasons there were to segregate the man as a prisoner subject to ACCT procedures, what other options had been considered and these were not recorded in the ACCT document or on the health screen, as Prison Service instructions require. Segregation reviews did not fully consider whether there were exceptional reasons to continue his segregation or indicate any active consideration of plans to move him.

90. Leicester is a small prison with no healthcare inpatient unit. In this case, we accept that the prison's options for holding the man safely were extremely limited. Nevertheless, we consider that a segregation unit is not usually an appropriate place for a mentally ill young man, recognised to be at risk of suicide and self-harm. Segregation units hold the most disruptive of prisoners and those receiving punishments of cellular confinement for breaches of prison discipline. The difficulty of combining this role with caring for vulnerable, mentally ill prisoners was illustrated on 29 August, the day he hanged himself, when segregation unit staff said that most of their time he been taken up dealing with one particularly disruptive prisoner. This meant that, contrary to Prison Rules, none of the prisoners in the segregation unit was able to spend any time out of their cell that day.

91. If, exceptionally, prison managers considered there was no other option but to hold the man in the segregation unit, then something should have been done to ameliorate his conditions. Giving vulnerable prisoners something to occupy their time is often a crucial part of safeguarding their welfare, yet we note that he lacked things to occupy him. For much of the time he did not even have a radio. Until he was given one, his only occupation seems to have been making models out of his food cartons.

92. The sad circumstances of the man's case highlight how difficult it is to manage and care properly for vulnerable mentally ill people in prison, especially in a prison such as Leicester, which has very limited facilities. Prisoners who are the most difficult to manage can also be the most vulnerable and we recognise that their behaviour can also be very damaging to others. Prison staff then have difficult decisions to make about where to hold such prisoners and frequently they are cared for in segregation units when all other options have been exhausted. This makes it all the more important to demonstrate fully that all options have been considered and that procedures designed to safeguard prisoners have been properly followed before segregation is used. We make the following recommendations:

The Governor should ensure that prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded; that segregation health screens are complete accurately; and there are fully documented reasons, including at segregation reviews, to explain the exceptional circumstances when such prisoners are segregated.

The Governor should ensure that mentally ill prisoners. or prisoners at risk of suicide and self-harm, held in the segregation unit have as full a regime as possible, that active efforts are made to reintegrate them to standard prison accommodation and that there are effective care plans to help prevent deterioration in mental health.

Segregation unit checks

93. There is no mandatory national instruction setting out the required frequency of checks for prisoners segregated under Prison Rule 45, for good order or discipline, as the man was, but it is mandatory that all segregated prisoners should be checked at an agreed frequency. Prison Service Order 1700, which governs segregation procedures, says that, "All prisoners located in the segregation unit must be observed by an officer at a frequency which is relevant to the individual's circumstances and will be based upon a case management approach. The observation level should be decided by the person authorising segregation. There are some prisoners that are familiar with segregation and may be at ease with it whilst a prisoner that is not familiar with it may need to be observed on a more regular basis which ideally would be at least hourly. All prisoners subject to Cellular Confinement must be observed at least hourly (unless on an open ACCT plan and this states more frequently)".

94. When the man was in the segregation unit at Leicester, the local practice, as in many prisons, was that officers checked all segregated prisoners every hour and logged the checks on their records. At the time of his original segregation, he was required to be checked four times an hour. When his ACCT was closed on 29 August, he was being checked once an hour. One of the reasons the custodial manager in charge of the segregation unit gave for closing that ACCT was that he would continue to be checked hourly, as this was the case for all prisoners in the segregation unit.

95. The man's segregation record for 29 August records that he was checked by Officer A at 4.30pm. However, CCTV shows that the officer did not do this. Leicestershire Police examined CCTV from earlier in the day and found that checks were recorded on his record at 9.00am, 10.00am, 12.30pm, 1.30m and 3.30pm. We understand that some checks were done but these did not correspond to the times on the records. He was last seen by Officer B at 4.53pm. No one checked him again before he was found hanged at 6.50pm. According to the local practice, he should have been checked again between 5.00 and 6.00pm. We cannot say that this check would have prevented his death but, as noted, the fact that segregated prisoners are checked hourly, was a factor in the decision to close his ACCT earlier that day. After the

police took a copy of the segregation record someone added a further entry to the records that were sent to us, which indicated that a check had been done at 5.30pm. This was not signed and the police have been unable to establish who was responsible.

96. Segregation unit officers told the investigator that the hourly checks are done as and when officers have the time. Officers do not always see the prisoner and sometimes, if they can hear a prisoner in his cell, they consider it is sufficient evidence to record that he is alive and well. PSO 1700 says that, "Where practical the segregation officer should engage in dialogue when making observations".

97. The investigator found that the officer who makes the checks is not necessarily the officer who records this on the segregation record. In the mornings, when one of the officers is completing adjudication paperwork in the unit office, that person completes the log when colleagues tell them the checks have been done, but not necessarily at that time. Officers said that the segregation records were therefore not an accurate reflection of when the prisoners had been checked or who had performed the checks.

98. After the man's death, the Governor issued a notice to segregation unit staff requiring them to check all segregated prisoners hourly. However, officers told the investigator that staffing levels and pressure of work in the segregation unit made it impossible for officers to make hourly checks and record these contemporaneously. We recognise the pressures on staff, but we note that there are only seven cells in the segregation unit at Leicester and the unit is not always full. It is for the Governor to decide whether resources are sufficient for required tasks.

99. The procedures at Leicester are not entirely in line with national Prison Service requirements as there is no individualised approach to setting frequency of observations for prisoners segregated for reasons of good order or discipline. Prisoners in segregation units are at higher risk of suicide and self-harm, even when their individual risk has not been recognised, and some checks are necessary. We note that hourly checks are mandatory for all prisoners serving punishments of cellular confinement. Unless a manager indicates otherwise, we consider checks for other segregated prisoners should replicate that. To be of value, the person carrying out the check should record it, as near as possible to the time it is made. We make the following recommendation:

The Governor should ensure that, unless managers set different levels of observations for individual prisoners, all segregated prisoners should be observed at least hourly, with a contemporaneous record completed by the person carrying out the check.

ACCT procedures

Case reviews

100. On 31 July, the first ACCT review was not multidisciplinary, but later that day, an operational manager, a mental health nurse, a psychiatrist and two officers held a second ACCT review. Neither of the staff at the first review were present. On 4 August, a custodial manager and officer conducted a review in the man's cell doorway. On 9 August, a custodial manager held a review on his own. On 12 August, a custodial manager and two officers held a review in the cell doorway. On 15 August, a custodial manager and a mental health nurse held a review without him present. On 22 August, a custodial manager, a mental health nurse and two officers held a review in a room in the segregation unit with him. On 29 August, a custodial manager and a mental health nurse held an ACCT review without him being present.

101. PSI 64/2011 requires ACCT case reviews to be multidisciplinary where possible and notes that the process will operate more effectively if there is continuity in attendance of staff from relevant departments and services. During his month at the prison, the man had eight ACCT reviews in the segregation unit. Only four of these had a member of healthcare staff present, despite his acknowledged mental health problems. One case review had just one member of staff present, which is entirely inappropriate. Few of the same staff attended reviews. Continuity of ACCT case managers is important to provide consistency of approach and to ensure identified issues are addressed and resolved over time. However, six different managers chaired the eight reviews.

102. PSI 64/2011, recommends that prisoners at risk of suicide and self-harm are managed under an enhanced case review process in a number of circumstances, including when they are subject to higher levels of unlock as the man was. Management by an enhanced review team is not mandatory, but it includes more specialists and a higher level of operational management. With the complexity of his behaviour and situation, we consider it would have been appropriate to consider an enhanced case review approach. While we are satisfied that the staff were caring towards him and genuinely wanted to help him, they were frustrated by their seeming inability to make progress with him. Records of reviews, some of which were held in inappropriately at his cell doorway, showed little evidence of a systematic approach to engaging him. A more high-level approach from an enhanced case review team might have helped.

Caremap

103. 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, family contact, 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 and be aimed at reducing risk to themselves and must be time bound

104. The man's ACCT was opened on 29 July, the day he arrived at the prison. However, there is only one entry in his caremap, and that was not made until 22 August, when a manager noted that he should take his medication. While we recognise that he did not cooperate with his ACCT assessment, it is concerning that staff did not identify any other issues, such as improving his very basic regime, which might have helped reduce his level of risk.

Risk assessment and closing the ACCT

105. PSI 64/2011 states the ACCT plan must only be closed once all the caremap actions have been completed and the case review team judges that the risk posed by the prisoner has been reduced. Additional guidance for prisoners in segregation includes that if a prisoner is likely to move to standard prison accommodation in a foreseeable time, the ACCT should remain open until the move has taken place.

106. On 9 August, a custodial manager closed the man's ACCT when he spoke to him alone in the doorway of his cell. When interviewed, he accepted that he should not have closed the ACCT on his own and should have held a multidisciplinary review, including a member of the mental health team. We are concerned that although he said he could see no value in keeping the ACCT open, there was no evidence that the man's risk had reduced. This was a rash decision and, three days later, staff opened the ACCT again when he was found with two ligatures in his cell, made from torn sheets.

107. We are also concerned that a manager and a mental health nurse decided to close the ACCT on 29 August. The manager told the investigator that the man was being checked hourly and had not harmed himself or shown any evidence of suicidal thoughts. (She was not aware that he had previously attempted suicide in 2013.) She said she was reassured by the fact that all segregation unit prisoners were checked hourly (which we now know not to have been the case.) She said she had heard that he might be moving from the segregation unit but there were no firm plans. The day before, the nurse had discussed with the Head of Safer Custody moving him to the substance misuse landing but was unaware that this might indicate the ACCT should not be closed. (The nurse had not received ACCT training at the time.)

108. The single action on the man's caremap, for him to take his medication, was ongoing and there was some doubt that he was taking it regularly. Just the day before, he had told an officer that he did not want to take his medication. Although he had shown some recent improvement, he remained largely uncommunicative and distressed. Just two weeks before he had been found with ligatures in his cell and he had a number of known risk factors for suicide and self-harm:

- He had previously attempted to take his own life

- He had a history of childhood adversity
- He had a history of mental illness
- He had had recent contact with psychiatric services
- He had low self-esteem
- He had a lack of social support and family contact
- His offence involved violence to another person
- It was his first time in prison
- He was only 21 years old

109. Between them, the manager and mental health nurse were aware of most of the man's risk factors. While ACCT procedures rely on staff judgement, at the time the ACCT was closed, we do not consider that staff fully considered or balanced his risk factors against his apparent improvement.

Conclusion

110. The man's behaviour and mental health presented undeniable obstacles to managing him effectively under the ACCT process. The difficulty was compounded by his segregation and the risk assessment that three officers needed to be present to open his cell. Nevertheless, there were some significant deficiencies in the ACCT process applied to him and we recommend that:

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

- **Holding multi-disciplinary ACCT reviews which ensure continuity of case management and include all relevant people involved in a prisoner's care and who are trained in ACCT procedures;**
- **Recording all relevant information about the risk of suicide and self-harm in the ACCT record;**
- **Using the enhanced case review process when appropriate;**
- **Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them;**
- **Ensuring before an ACCT is closed that a multidisciplinary team review the risk and record and consider all risk factors and that all caremap actions have been completed.**

Mental Health treatment

111. The man received daily supervision from the mental health in-reach team in prison. Healthcare staff requested and received his community mental health notes and his GP notes very soon after he arrived at the prison. A prison psychiatrist first assessed him the day after he arrived. Generally we are satisfied that he received appropriate mental health care in prison and more than he would have received in any other setting, other than an inpatient psychiatric unit. Healthcare staff made appropriate efforts to seek a transfer to a psychiatric unit, but, unfortunately, he was not considered suitable.

112. After the man's death, a serious untoward incident review completed on behalf of Leicestershire Partnership Trust highlighted the following issues of concern:

- His community mental health records were scanned into his medical record but no one appears to have read them or highlighted the important information they contained.
- His mental health careplan was not in the correct place in his medical record, which meant it was not easy for staff to refer to.
- A consultant psychiatrist's visit was not recorded on his medical record.
- A mental health nurse had not received ACCT training when she agreed with a manager to close his ACCT.

113. Of these, the first is of most concern. It is unfortunate that having obtained the man's community records commendably swiftly from his community psychiatric nurse, that the important information gathered was not shared. This was the clearest source of information about his past risk of suicide. Most of the staff interviewed said they were not aware that he had previously attempted to kill himself. Assessing risk is not an exact science but a previous attempt is one of the biggest indicators that a person is at risk of suicide. It is vital that all relevant information about risk is shared and properly considered.

114. The investigator asked the mental health team leader what she had done in response to these concerns. She said that since the man's death:

- The mental health team have started a daily communication book that logs incoming information.
- There is also now a fortnightly caseload review on Fridays.
- Before his death, hard copies of information received were kept in an ad hoc way but the mental health team now has individual patient files.
- Each nurse now has an in-tray and hard copies of all patient information are put in the relevant tray.
- They are in the process of embedding a new mental health care pathway and templates.
- A nurse had joined the mental health team in January 2014 and the last ACCT training had been in December 2013. All mental health staff had now been booked on ACCT training which would take place before June 2015.

We are satisfied that the prison has responded appropriately to the issues raised and make no recommendation.

RECOMMENDATIONS

1. The Governor should ensure that prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded; that segregation health screens are completed accurately; and there are fully documented reasons, including at segregation reviews, to explain the exceptional circumstances when such prisoners are segregated.

2. The Governor should ensure that mentally ill prisoners, or prisoners at risk of suicide and self-harm, held in the segregation unit have as full as regime as possible, that active efforts are made to reintegrate them to standard prison accommodation and that there are effective care plans to help prevent deterioration in mental health.

3. The Governor should ensure that, unless managers set different levels of observations for individual prisoners, all segregated prisoners should be observed at least hourly, with a contemporaneous record completed by the person carrying out the check.

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

    - Holding multi-disciplinary ACCT reviews which ensure continuity of case management and include all relevant people involved in a prisoner's care and who are trained in ACCT procedures;
    - Recording all relevant information about the risk of suicide and self-harm in the ACCT record;
    - Using the enhanced case review process when appropriate;
    - Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them;
    - Ensuring before an ACCT is closed that a multidisciplinary team review the risk and record and consider all risk factors and that all caremap actions have been completed.

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Governor should ensure that prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded; that segregation health screens are completed accurately; and there are fully documented reasons, including at segregation reviews, to explain the exceptional circumstances when such prisoners are segregated.	Accepted	A checklist document has now been produced by region to assist establishments in their decision making when a prisoner is located in segregation unit on an open Assessment Care in Custody and Teamwork (ACCT) or have their segregation maintained whilst an ACCT is opened. This will support local establishments in recording the considerations that need to be taken into account when deciding to keep a prisoner who is on an open ACCT in segregation. All decisions made about an identified at-risk prisoner will be recorded in their ACCT Plan. Prisoners on an open ACCT who are in segregation, will be visited daily by the Duty Governor who will confirm the decision of the case review team that the location continues to be appropriate. If the Duty Governor considers the location to be inappropriate they will arrange a case review to discuss it. All of the health screens of prisoners on open ACCTs will be quality checked by the Head of Safer Custody and feedback will be given on any deficiencies in quality. Segregation Reviews will be conducted by the Head	Target date for completion: 01/07/15 Governor	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
			of Safer Custody with Mental Health In-Reach Team, the Offender Supervisor, a member of the Independent Monitoring Board and Chaplaincy being invited to attend. Awareness will be raised for all Band 5's & 7's around understanding the use of segregation, case management and care mapping. This will be via a briefing pack, to be written to reflect the concerns identified in this report along with other generic PPO recommendations. This will also be shared with staff at all grades via safer custody briefings. Speed Briefings will also be developed and delivered at Morning Briefings to all staff that reflect local issues identified through quality checks.		
2	The Governor should ensure that mentally ill prisoners, or prisoners at risk of suicide and self-harm, held in the segregation unit have as full as regime as possible, that active efforts are made to reintegrate them to standard prison accommodation and that there are effective care plans to help prevent deterioration in mental health.	Accepted	Individual Support Plans are written for all prisoners held in segregation for over 72 hours. These are shared on CNOMIS case notes. They will include how we best occupy the time of these prisoners with a combination of existing regime, bespoke interventions and plans for re-integration onto normal location. The Support Plans are written as part of the	Governor	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
			multidisciplinary review process which includes providing activities to occupy time and encourage re-integration. Mentally ill prisoners will be designated a named mental health nurse who will attend all reviews, case management discussions and visit the prisoner as part of the assessment process.		
3	The Governor should ensure that, unless managers set different levels of observations for individual prisoners, all segregated prisoners should be observed at least hourly, with a contemporaneous record completed by the person carrying out the check.	Accepted	Governor's Order 019/14 published on 18/12/14 reiterates the policy that prisoners in segregation must be checked hourly regardless of the Prison Rule they are detained there under; unless the frequency is increased in the ACCT document. The Duty Governor, when carrying their segregation round, will quality assure the records.	Completed Governor	
4	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: • Holding multi-disciplinary	Accepted	All ACCT reviews of prisoners held in the segregation will take place with the key staff involved in that prisoners care attending, including a named mental health nurse who is familiar with the prisoner, the safer custody lead and the named case manager. Segregation staff who have day to day	Governor	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	ACCT reviews which ensure continuity of case management and include all relevant people involved in a prisoner's care and who are trained in ACCT procedures; • Recording all relevant information about the risk of suicide and self-harm in the ACCT record; • Using the enhanced case review process when appropriate; • Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them; • Ensuring before an ACCT is closed that a multidisciplinary team		responsibility for that prisoner will also attend and contribute. All information related to prisoners risk and needs will be recorded in the ACCT record and will be subject to rigorous management checks. For all prisoners in the segregation unit on an ACCT an enhanced case review will be completed. ACCT care maps will be reviewed at the weekly Order and Control Meeting to ensure that actions are being completed and updated as new information comes to light – the prisoner will be involved in the ACCT Care map and it will be reviewed frequently. ACCT care maps to be reviewed at the weekly Order and Control Meeting to ensure that actions are being completed. A multidisciplinary team will review the risk and all issues including involvement from mental health before an ACCT is closed. Speed Briefings will be developed and delivered at Morning Briefings to all staff which will identify the issues that have been identified through the quality checks and in this and other PPO report and other.	01/07/15 17/07/15	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	review the risk and record and consider all risk factors and that all caremap actions have been completed.		There is a clear system of Management Checks for ACCT documents covering the opening, management & closure of ACCT documents. This is linked to the safer custody meeting, local awareness and fed directly back to the Case Manager. Ongoing Monthly Introduction to Safer Custody Training will target all staff including outside agencies, who have contact with prisoners. Local awareness will be raised of PSI 64/2011 reflecting local issues identified, through the Safer Custody Meetings. The Region will develop a regional training plan proposal that includes training on Introduction to Safer Custody, ACCT Assessor and Case Manager. There is currently consultation taking place to determine trainer availability and demand. A proposal will be written for presentation at the Regional Safer Custody meeting on 17th July for agreement.	01/08/15	