

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ondrej Suha a prisoner at HMYOI Brinsford on 25 December 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**



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

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

Mr Suha was Slovakian but had spent most of his life in this country. On 21 December 2015, he was found hanged in his cell in HMYOI Brinsford and died in hospital four days later, on Christmas Day. He was 19 years old. I offer my condolences to Mr Suha's family and friends.

Mr Suha had tied a ligature around his neck three weeks before he hanged himself. I am concerned that prison staff ended suicide and self-harm prevention procedures within 24 hours, without any proper healthcare input and without fully considering or resolving Mr Suha's problems. On 21 December, he received papers from the Home Office notifying him he might be deported at the end of his sentence. His offender supervisor spent some time talking to Mr Suha and believed they had agreed a plan to help resolve this. He did not believe that Mr Suha was suicidal. Despite Mr Suha's actions later that evening, I consider that his decision not to begin monitoring procedures was reasonable at the time. However, there were serious deficiencies in the emergency response procedures, including a delay of over seven minutes before anyone tried to resuscitate Mr Suha after he was found hanged.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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Summary

Events

1. Mr Ondrej Suha was remanded to HMYOI Brinsford on 12 September 2015. He was 19 years old and had spent a brief period on remand in prison earlier in 2015. Mr Suha was Slovakian but had lived in the United Kingdom for most of his life. When he arrived at Brinsford, staff did not identify any risk of suicide or self-harm.
2. At the end of October, Mr Suha was moved to a supported living unit at Brinsford for prisoners who are regarded as more vulnerable. The exact reasons were not recorded, although he appeared to be in debt to other prisoners for tobacco. His offender supervisor arranged for him to get an advance of tobacco from the prison shop to pay back the debt. Mr Suha had a court appearance on 7 December and hoped to be released on bail but was worried that this would not happen as he had nowhere to live.
3. On the evening of 30 November, Mr Suha twice tied ligatures around his neck. The duty manager began Prison Service suicide and self-harm procedures, known as ACCT.
4. A member of the safer custody team assessed Mr Suha on 1 December, and noted that he was concerned about bail accommodation and said that prison staff had not listened to him. She recorded that his forthcoming court appearance might be a trigger for suicide or self-harm. Later that day, at the first case review, a supervising officer, acting alone, ended the ACCT monitoring. There was no healthcare representative at the review and Mr Suha's bail accommodation problem, which had led to his self-harm, had not been resolved.
5. On 7 December, Mr Suha was not bailed but was convicted and sentenced to 14 months in prison. This meant he was liable to be deported and the Home Office served papers on 21 December. Mr Suha's offender supervisor explained he had the right to make representations before a decision was made. He agreed to contact Mr Suha's family to ask them about his immigration status and find a solicitor to represent him. His offender supervisor thought their conversation had addressed the problem and said he saw nothing to make him think that Mr Suha was suicidal.
6. That night, officers could not get a response from Mr Suha who had covered the observation panel in the door, but they saw he appeared to be in an unnaturally high position. Although they were concerned about Mr Suha, there was a delay of some minutes opening the cell. The officers radioed an emergency code and, when they went in, they found Mr Suha hanged. They cut the ligature from around Mr Suha's neck but no one began cardiopulmonary resuscitation until a nurse arrived seven minutes later. The control room officer did not call an ambulance until the nurse asked for one. Paramedics arrived and took Mr Suha to hospital, but he never recovered and died in hospital on 25 December. His mother and his sister were with him at the time.

Findings

7. Although Mr Suha hanged himself shortly after receiving the news that he might be deported, his offender supervisor who had delivered the message did not consider he appeared suicidal and believed they had agreed a plan to help Mr Suha make representations. We have no reason to question his assessment and we do not consider he could have anticipated Mr Suha's actions. However, we are concerned that the earlier very brief period of ACCT monitoring ended too early on 1 December, without full consideration or resolution of Mr Suha's documented issues and without proper input from healthcare staff.
8. The emergency response was very poor. It took staff too long to go into Mr Suha's cell and too long to call an emergency ambulance. There was also a delay in a nurse arriving and no one began cardiopulmonary resuscitation until she arrived.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
 - First case reviews are multidisciplinary and always include a member of healthcare staff.
 - Staff record information about all acts of self-harm in the ACCT document.
 - Case reviews assess risk in line with ACCT guidance.
 - ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
 - All night staff carry individual emergency cell keys, enter cells as quickly as possible in a life threatening situation, and initiate basic life support promptly when needed.
 - Control room staff call an ambulance as soon as an emergency code is broadcast.
 - Healthcare staff are able to reach prisoners quickly when there is an emergency at night.

The Investigation Process

9. The investigator issued notices to staff and prisoners at Brinsford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Brinsford on 7 January 2016 and obtained copies of relevant extracts from Mr Suha's prison and medical records.
11. The investigator interviewed five prisoners who knew Mr Suha when he visited Brinsford on 7 January. He interviewed another prisoner by telephone on 29 January. On 10 and 11 February, he interviewed 12 members of staff at Brinsford.
12. NHS England commissioned a clinical reviewer to review Mr Suha's clinical care at the prison.
13. We informed HM Coroner for South Staffordshire of the investigation and have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Suha's cousin, who represented his family, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Suha's cousin asked how many staff were on duty on the night that Mr Suha hanged himself and for details of the emergency response. She asked whether Mr Suha had been told he was to be deported and whether this led to his actions.
15. Mr Suha's family received a copy of the initial report. They did not make any comments.

Background Information

HM Young Offender Institution (YOI) Brinsford

16. HMYOI Brinsford holds up to 577 remanded and sentenced young adult men aged 18-21 across five residential units. Residential Unit 1, consisting of A Wing and C Wing, is a supported living unit for young men who find it difficult to adapt to prison life. Staffordshire and Stoke-on-Trent Partnership NHS Trust provide healthcare services.

HM Inspectorate of Prisons

17. The most recent inspection of Brinsford was in February 2015. Inspectors reported that incidents of self-harm had reduced by a third since their previous inspection and the quality of ACCT documents had greatly improved. They noted that there were a lot of violent incidents and many prisoners felt unsafe, although the supported living unit was a positive initiative to help the most vulnerable. Inspectors found that provision for foreign national prisoners was reasonably good and relationships between staff and prisoners were a strength.

Independent Monitoring Board

18. 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 latest annual report, for the year to July 2015, the IMB reported that the quality of ACCT documents had improved due to additional staff training. They reported that bullying was a major concern at Brinsford. The IMB was concerned that the healthcare service might be overstretched at night if an incident occurred.

Previous deaths at HMYOI Brinsford

19. Mr Suha was the first prisoner to die at Brinsford since 2009.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. On 24 March 2015, Mr Ondrej Suha was remanded to HMP High Down, charged with theft. This was his first time in prison. He was Slovakian but had lived in the UK since he was a child. At an initial routine health screen, Mr Suha said he had no physical or mental health problems and he had never harmed himself. After appearing at Youth Court the next day, Mr Suha transferred to HMP Forest Bank. He was released on 17 April, after he received a community order.
22. On 12 September, Mr Suha was remanded to HMYOI Brinsford, charged with burglary and assault. His sister and mother were the victims. A nurse assessed Mr Suha and noted that he was physically well and had no thoughts of self-harm. An officer who interviewed Mr Suha on his first night recorded that he had settled in well. No one considered he was at risk of suicide and self-harm.
23. There is little information about Mr Suha's first six weeks at Brinsford. On 29 October, he moved to the supported living unit. No one recorded a reason for the move. A Supervising Officer (SO), who was Mr Suha's offender supervisor (offender supervisors oversee the implementation of sentence plan targets in prison) and knew him well, suggested that it was because he was naïve about prison life.
24. On 5 November, Mr Suha told his offender supervisor that he was in debt to other prisoners for tobacco and they had threatened him. He would not give their names, but said that the prisoners threatening him were in a different unit. He referred Mr Suha to the violence reduction officer. Mr Suha also told his offender supervisor that he had no contact with any family or friends since he had arrived at Brinsford, as he did not know their telephone numbers. He said he would try to help.
25. On 6 November, the violence reduction officer offered Mr Suha the support of the wing's violence reduction representatives. (These are prisoners who mediate in minor disputes and negotiate between parties to settle debts.) However, Mr Suha was adamant that he did not want to involve them. The officer said his impression was that Mr Suha did not want other prisoners to view him as an informant. The officer asked one of the supported living unit's mentors to speak to Mr Suha. (Mentors are trusted prisoners who live in the unit to support other prisoners and promote a stable environment.) The officer noted that he would review the situation in a week, but there is no record that he did.
26. The offender supervisor found a telephone number for one of Mr Suha's sisters and spoke to her, but she said that she and her mother did not want any contact with Mr Suha at the time. He told Mr Suha, and noted that he accepted this. He established that Mr Suha knew his girlfriend's address and he advised him to write to her.
27. On 20 November, Mr Suha told his offender supervisor that he was still in debt and owed another prisoner two packets of tobacco. As before, Mr Suha would not name the prisoner. The offender supervisor arranged for Mr Suha to receive an advance of tobacco from the prison shop to pay off the debt. Mr Suha later told him that he had done this and was no longer in debt.

28. Mr Suha told his offender supervisor that he needed help finding a bail address before his next court appearance on 7 December. The offender supervisor emailed a member of the prison's offender management unit to ask her to help, although he later found out that he had contacted the wrong person.
29. On 30 November, prison officers warned Mr Suha about several minor breaches of prison discipline, after which the records show that he had flooded the wing landing. The offender supervisor spoke to him after this incident. He told us that it was clear to him that Mr Suha was copying the behaviour of the prisoner in the cell opposite. Mr Suha again said he was worried about getting a bail address before his court appearance on 7 December. The offender supervisor said that he would look into this in the morning. He told us that, when he left the wing after the evening meal, Mr Suha had calmed down and appeared to be his usual self.
30. Later that evening, Mr Suha tied a ligature around his neck. (Prison staff did not record what material he used to make the ligature.) His cellmate alerted officers who removed the ligature. An officer recorded that Mr Suha had pulled the ligature tight and was turning red. Mr Suha tried to fight off the officers who came into the cell and they restrained him. The duty manager persuaded Mr Suha to speak to her. He said that he expected to get bail at his court appearance but was worried as he had nowhere to live and this might affect his chances of being released on bail. She said that she would speak to his offender supervisor about this. She began ACCT procedures.
31. Shortly after he returned to his cell, Mr Suha tied another ligature around his neck. The duty manager spoke to him again and explained that she could not resolve his issue that night, but would speak to his offender supervisor in the morning. No one recorded in the ACCT document or elsewhere that Mr Suha had twice tied ligatures.
32. On 1 December, the offender supervisor spoke to a worker in the prison's offender management unit about Mr Suha's bail address. He recorded that she would see Mr Suha the next day.
33. That afternoon an administrative officer from the safer custody team assessed Mr Suha as part of ACCT procedures. Mr Suha said that he had been forced to "string up" as prison staff had not listened to him. She recorded that Mr Suha said he did not want to die but wanted someone to help him. Mr Suha said he was due in court on 7 December, and hoped to be released on bail but had no bail address. He said he had asked several times to see someone from Bail Accommodation and Support Services (BASS, who provide community accommodation for offenders on bail or home detention curfew), but no one had come. Mr Suha told her that he did not speak to his family and his girlfriend was his only support. She recorded that Mr Suha urgently needed to see his offender supervisor and housing workers to secure a bail address. She recorded that his court appearance might be a trigger for suicide or self-harm. She told us she did not know that Mr Suha had made two separate ligatures the previous evening.
34. Later that afternoon, a SO held the first ACCT case review. Prison Service Instruction (PSI) 64/2011 has a mandatory instruction that the assessor attend with, wherever possible, the member of staff who raised the initial concern, and a member of healthcare staff. If those invited cannot attend in person,

exceptionally they can give a written account of their input. The administrative officer said that she spoke to the SO by telephone after the assessment, but did not attend as it was not logistically possible.

35. There was no other member of staff present at the case review other than the SO, although the offender supervisor was on the wing at the time and spoke to Mr Suha during the review. He told Mr Suha that he had spoken to the worker in the offender management unit and she would explore whether he could get housing through BASS. He telephoned a nurse and asked if Mr Suha had any mental health issues he should consider. She told us that she did not know Mr Suha but checked his medical record and advised the SO that there were no issues recorded about his mental health.
36. The SO said he concluded that Mr Suha was at low risk of suicide and self-harm because he understood that the offender supervisor was addressing his housing issue. He told us that he did not know Mr Suha had tied two separate ligatures the evening before. Despite Mr Suha's recent self-harm, the SO concluded that it was appropriate to end ACCT monitoring as Mr Suha had taken part in the review, prison staff were addressing his issues and there was no indication that he intended to harm himself. He said he did not think Mr Suha was in crisis.
37. On 3 December, the worker from the offender management unit completed a referral to BASS. She asked them to prioritise the application because of Mr Suha's imminent court appearance but recorded that they were unable to do this because of a backlog of work.
38. On 7 December, Mr Suha appeared at court by video link. He pleaded guilty and was convicted and sentenced to 14 months in prison. The administrative officer recorded that she had told wing staff that Mr Suha had a court appearance and asked them to check on him afterwards, although there is no record that anyone did. Two days later, a SO saw Mr Suha for an ACCT post-closure review. The SO said that Mr Suha seemed happy and settled and said he had no concerns. They did not discuss his court appearance and sentence. He concluded that there were no reasons to reopen the ACCT.
39. On 13 December, the offender supervisor discussed his sentence with Mr Suha and he said he was "okay" with it, as it was relatively short compared to some of the other prisoners on his wing. He was keen to apply for release on home detention curfew (HDC), and asked about release accommodation. (HDC enables eligible prisoners to be released up to 135 days before the halfway point in their sentence, subject to an electronically monitored curfew. Foreign national prisoners liable to removal from the UK are barred from the scheme.) The offender supervisor told him that BASS had said that they would not accept Mr Suha because of problems when he had stayed in their properties before. He told Mr Suha that he would speak to his offender manager (probation officer) to see if they could find accommodation but, if they could not find anywhere suitable, he would have to stay in prison until his release date in April 2016. He recorded that Mr Suha was "happy" about this.
40. On 15 December, the offender supervisor contacted the Home Office. He explained that Mr Suha was Slovakian and had been sentenced to 14 months in prison. He asked them to clarify whether Mr Suha was liable for deportation and

whether the prison could consider him for release on HDC. He saw Mr Suha on the same day and explained the questions he had asked the Home Office. He told us that Mr Suha appeared “nonplussed” by the news that he could be deported, but asked how long it would take to find out. He told him that he had asked for a quick decision so they knew whether they could proceed with HDC, as Mr Suha’s eligibility date for HDC was in late December.

41. Mr Suha’s cellmate said that Mr Suha did not expect to be deported and was stressed when the offender supervisor told him it was a possibility. He said that Mr Suha was also stressed about his relationship, as he had written to his girlfriend but she had not replied. Another prisoner told us that Mr Suha’s girlfriend was pregnant and, around a week or two before Mr Suha died, had written to him to say she would not let him see their baby. He said that Mr Suha did not want to talk about this. The prisoner told an officer about the letter. She said she remembered speaking to Mr Suha about this but had little recollection of the conversation and did not note anything about it in Mr Suha’s prison record. Other prison staff we spoke to, including the offender supervisor, were not aware that Mr Suha had any problems with his girlfriend.
42. On 17 December, Mr Suha’s cellmate tried to hang himself in the cell while Mr Suha was present. The next morning, Mr Suha’s cellmate moved to another cell to share with a friend. Mr Suha shared with another prisoner for one night before moving into a single cell, at his request, on 19 December.
43. On 21 December, the Home Office wrote to Brinsford and asked them to serve a ‘notice of liability to make a deportation order’ on Mr Suha. This meant that the Home Office would deport Mr Suha from the UK if he did not give reasons why he should be allowed to stay. They gave Mr Suha 20 working days to make representations.
44. The offender supervisor said he arrived in Mr Suha’s unit at around 4.00pm, and saw a number of prisoners about various matters. He did not speak to Mr Suha immediately as Mr Suha was still at work. When he got back from work, Mr Suha said he wanted to spend some time with other prisoners and he agreed to see him afterwards.
45. At 6.25pm, Mr Suha and other prisoners were locked in their cells for the night, but the offender supervisor unlocked Mr Suha at 6.40pm and spoke to him in a room on the wing. He gave him the immigration document and explained what it meant. He said Mr Suha was shocked when he told him the news. Mr Suha told him he did not want to be deported and that he would refuse to go. He asked Mr Suha if he knew of any grounds to remain in the UK. He said that Mr Suha did not seem to know anything about his immigration status. He explained to Mr Suha that he had 20 working days to respond to the Home Office. He said that he would contact immigration solicitors the next morning to arrange for them to represent Mr Suha. Mr Suha also asked him to contact his sister. He said he would do this in the morning and would ask her about Mr Suha’s immigration status. He said that Mr Suha asked if the notice meant that he would definitely be deported. He explained that this was not what it meant, as Mr Suha had the opportunity to give reasons why he should remain in the UK. He said Mr Suha seemed happy with this and the plan they had agreed for the morning. He said

that Mr Suha's initial shock dissipated during their conversation and, by the end of it, he was "buoyant". He said he did not consider beginning ACCT procedures because Mr Suha seemed happy and settled and understood that they would address the issue the next morning.

46. The offender supervisor locked Mr Suha in his cell at 7.10pm. He made a note in the wing observation book about his conversation with Mr Suha and told the night manager.
47. A prisoner in the cell next door to Mr Suha said he spoke to him when he got back to his cell. He said that Mr Suha had told him that he might be deported as the Home Office thought he had come to the UK illegally and prison staff were trying to find a national insurance number for him. He said that Mr Suha did not seem bothered by the news and had said it was not definite that the Home Office would deport him.
48. A prisoner in the other neighbouring cell said that Mr Suha told him he had spoken to his offender supervisor about the possibility of release on HDC. Mr Suha said he did not think he would be released. He said that Mr Suha sounded upset, but not unusually so. They finished speaking at around 8.45pm. Closed circuit television (CCTV) coverage shows that Mr Suha switched his light off at 8.46pm.
49. An officer and two operational support grades patrol the supported living unit at night. On the night of 21 December, staff working on the unit starting at around 8.45pm. The night manager briefed them on the day's events, including that Mr Suha had been told that the Home Office might deport him.
50. The OSG 1 began a check of cells at around 9.00pm. He arrived at Mr Suha's cell at 9.01pm and found that Mr Suha had covered the observation panel with toilet paper. He shouted to Mr Suha and kicked the door, but there was no response. Around 30 seconds later, Officer A arrived at the cell and tried unsuccessfully to get a response from Mr Suha. Officer A said that, around a minute after he arrived at the cell, the toilet paper moved slightly and he could see Mr Suha's hand near the door in an unnaturally high position.
51. At 9.04pm, Officer A and the OSG 1 both left the cell for 40 seconds, but appeared to be confused about the reasons. For security reasons, staff do not carry standard prison keys at night but have a cell key in a sealed pouch for use in an emergency. Officer A said they had gone to get the sealed cell key, which the night staff share, from the office in the unit. The OSG said that he was carrying the sealed cell key and they had left the cell to try to find OSG 2 for additional support. When they returned at 9.05pm (without OSG 2), Officer A radioed a code blue medical emergency, indicating a life threatening situation. They then opened the cell and found Mr Suha hanged from a ligature made from a bed sheet which he had attached to the light fitting. The officer cut the ligature and they placed Mr Suha on the floor in the recovery position. He checked Mr Suha's pulse but could not find one. He told us that Mr Suha was not breathing. Neither he nor OSG 1 tried to resuscitate Mr Suha. Both told us that they had not been trained in cardiopulmonary resuscitation.

52. The emergency response nurse does not have keys at night and has to wait in the healthcare centre until the night manager or their assistants collect them to attend a medical emergency. Staff went to collect a nurse and arrived at Mr Suha's cell at 9.12pm. The nurse began cardiopulmonary resuscitation and asked the control room operator to call an ambulance. Two officers took over chest compressions while the nurse attached a defibrillator, which found no shockable heart rhythm. The staff continued chest compressions until paramedics arrived at 9.25pm and took over emergency treatment.
53. The paramedics re-established a pulse and, at around 10.00pm, took Mr Suha to the intensive care unit at hospital. The hospital placed Mr Suha on a life support machine, but he never recovered and died in the afternoon of 25 December.

Contact with Mr Suha's family

54. The duty governor telephoned Mr Suha's sister after his admission to hospital, but received a message that the call could not be accepted. He asked the police to visit Mr Suha's sister and mother during the night, but they received no answer at either address. The police went back to Mr Suha's sister's home on the morning of 22 December, and told her that he had been admitted to hospital. Several family members visited Mr Suha over the following days, and his mother and sister were with him when he died. Mr Suha's funeral was held on 14 January 2016 and the prison contributed to the costs in line with national instructions.

Support for prisoners and staff

55. On 22 December, the duty governor spoke to the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
56. The prison posted notices informing other prisoners of Mr Suha's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Suha's death.

Cause of death

57. The hospital recorded the cause of death as multiple organ failure and hypoxic brain injury, caused by asphyxiation due to hanging.

Findings

Identification of risk of suicide and self-harm

58. The Prison Service Instruction (PSI) 64/2011 on ACCT suicide and self-harm prevention procedures says that all staff who have contact with prisoners must be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm and take appropriate action. All prisoners identified as at risk of suicide and self-harm should be managed under ACCT procedures. We have considered whether staff at Brinsford should have recognised Mr Suha as at risk on 21 December and begun ACCT monitoring.
59. Mr Suha had some risk factors for suicide and self-harm, which are listed in PSI 64/2011. He had recently harmed himself by tying ligatures tightly around his neck. He had said that he was in debt and that other prisoners had threatened him (although he appeared to have resolved these issues). He had little external support, he had been convicted of a violent offence against a family member and he had relationship difficulties. PSI 64/2011 says that when foreign national prisoners are, or are about to be, held on a deportation order, or are close to deportation, this can be a trigger for suicide and self-harm.
60. The offender supervisor gave Mr Suha immigration papers telling him that he might be deported, shortly before he was found hanged. It might have been more prudent to have waited until the next day, rather than giving a vulnerable young man this difficult news just as he was locked in his cell for the night on his own. However, he knew Mr Suha well and was aware of his vulnerabilities, some of which he had helped to resolve. He went out of his way, after his shift had ended, to spend some time speaking to him about the situation. He told us that he had explained to Mr Suha that the papers did not mean he would definitely be deported. He agreed that he would contact Mr Suha's sister to find out more about his immigration status and would identify an immigration solicitor to represent him the next morning. He told us he was satisfied Mr Suha understood that they had a plan in place to address the issue. He did not therefore think that Mr Suha was at increased risk of suicide and self-harm.
61. Staff judgement is fundamental to managing the risk of suicide and self-harm and staff have to use their experience and skills to assess risk, as well as following the national guidance. After the offender supervisor told Mr Suha on 21 December that he might be deported, he considered Mr Suha's reaction and spent some time with him addressing the issue and they made a plan together about how they would respond. He made sure that other staff were aware that Mr Suha had received bad news and when he left Mr Suha he believed that he had helped him begin to address the problem. While Mr Suha's subsequent actions would suggest that his assessment was incorrect, we have no reason to question his judgement, which was based on his knowledge of Mr Suha and how he had reacted to the news. We therefore consider it was not unreasonable for him to conclude that Mr Suha did not need to be monitored under ACCT procedures. Despite his range of risk factors, Mr Suha appeared to have settled at the prison and it would have been difficult for staff to anticipate or prevent his actions.

ACCT procedures

62. Mr Suha was managed under ACCT procedures very briefly, three weeks before he hanged himself. We are concerned that the procedures were poorly managed and did little to support him. While this might not have affected the eventual outcome, it is possible that more effective ongoing support might have helped address Mr Suha's underlying risk of suicide.
63. A supervising officer, acting alone, ended ACCT monitoring on 1 December, less than 24 hours after Mr Suha had tied two ligatures around his neck. PSI 64/2011 requires case reviews to be multidisciplinary where possible and says that, for the first case review, among others, the assessor, the person who raised the initial concern, and a healthcare representative must attend. A SO held the case review on his own, although the offender supervisor spoke to Mr Suha briefly during the review to let him know that he was trying to find out what was happening about his bail accommodation. The SO had telephoned a nurse before the review and asked about Mr Suha's medical history. However, she said she did not know why the ACCT was opened or that it was a first case review, and she had never met Mr Suha. She said that healthcare staff do not routinely attend ACCT case reviews.
64. Guidance in the ACCT document says that staff can end ACCT procedures at the first case review, if the case review team believe it is safe to do so and if all issues identified in the assessment interview are resolved. At the assessment, an administrative officer had identified that Mr Suha was concerned about where he would live if the court released him on bail at his hearing a week later. She had also recorded that the court appearance might be a potential trigger for suicide or self-harm. The offender supervisor told Mr Suha that someone would look into whether he could get bail accommodation and the SO said that this was one of the reasons he ended ACCT monitoring. However, Mr Suha had been aware that staff were investigating bail accommodation for him when he tied the ligatures around his neck the previous evening. He had still not received an answer and this issue was not resolved.
65. The SO recorded that Mr Suha was at low risk of suicide and self-harm. He told us that he thought Mr Suha had tied one ligature around his neck the previous evening (an officer recorded in the ACCT document that Mr Suha had tied the ligature tightly around his neck and was turning red when he arrived at the cell). There is no record in the ACCT document or elsewhere that Mr Suha tied more than one ligature. We consider that this underestimated Mr Suha's risk so soon after his self-harm. Guidance in the ACCT document is that risk is low when there has been no self-harming behaviour. Current self-harming behaviour, even if there is no immediate intent or a specific plan, indicates that risk is raised.
66. The SO told us that he closed the ACCT because Mr Suha engaged with the review, prison staff were addressing his issues and there was no indication that he intended to harm himself. We are concerned that he made this decision alone, less than one day after Mr Suha's self-harm and at an ACCT case review which was not multidisciplinary. Even when multidisciplinary attendance is not possible, it is implicit that decisions at ACCT case reviews, which are based on teamwork, involve more than one member of staff. Mr Suha's court appearance

was listed as a potential trigger for self-harm, but the SO ended ACCT procedures before he knew the outcome and before he knew whether anyone had found possible bail accommodation. He did not appropriately consider Mr Suha's level of risk and, instead, relied too heavily on what Mr Suha told him. We make the following recommendation:

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

- **First case reviews are multidisciplinary and always include a member of healthcare staff.**
- **Staff record information about all acts of self-harm in the ACCT document.**
- **Case reviews assess risk in line with ACCT guidance**
- **ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved.**

Emergency response

67. We have a number of concerns about the emergency response on the night of 21 December. The three night staff on the supported living unit share a cell key, but the two staff who were concerned that Mr Suha had hanged himself appear to have been confused about where to find the key. This meant there was a delay of around 40 seconds before Officer A and OSG 1 opened Mr Suha's cell door. If all three night staff on the unit carried their own individual key, there would be no need for such a delay. When there is a potentially life threatening situation, it is essential to act quickly. We would normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life. The two night staff should have entered Mr Suha's cell immediately.
68. The officer appropriately radioed a code blue medical emergency before he and the OSG went into the cell. However, there was a delay of several minutes before the control room called an ambulance. The officer who worked in the control room said that the local practice is to wait for a prison nurse to ask for an ambulance.
69. PSI 03/2013 says that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly says that control room staff should automatically call an ambulance whenever there is an emergency code and it must not be a requirement for a member of the prison healthcare team or a duty manager to attend the scene before emergency services are called. Brinsford's protocol for code red and code blue emergency procedures reflects this but this does not appear to be the actual practice.
70. We are also concerned that Officer A and OSG 1 did not try to resuscitate Mr Suha. This led to a delay of around seven minutes until a nurse arrived and began cardiopulmonary resuscitation (CPR), which is too long. Brinsford's Local Instruction 2.087 says that, following the discovery of an actual or suspected death in custody at night, staff must 'give appropriate medical first aid'. Both the officer and OSG said they did not try to resuscitate Mr Suha because they are

untrained. We consider that all prison staff should have some awareness of how to begin CPR, if only from widely broadcast public information films. We note that the officer carried out chest compressions after the nurse arrived.

71. At night, healthcare staff do not have keys to enter the prison wings and they have to wait for the night manager or their assistants to take them to the scene of an emergency. This meant that it took seven minutes for the nurse to arrive at Mr Suha's cell, which is too long in an emergency. We consider prisons should do everything they can to ensure that the preservation of life is placed over security arrangements and this practice caused an inherent delay.
72. The accumulation of delays in the emergency response is particularly concerning as paramedics managed to restore Mr Suha's pulse before taking him to hospital. We cannot know whether a prompt, more effective response would have made a difference to the outcome for Mr Suha, but early intervention when someone is found hanging can save their life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **All night staff carry individual emergency cell keys, enter cells as quickly as possible in a life threatening situation, and initiate basic life support promptly when needed.**
- **Control room staff call an ambulance as soon as an emergency code is broadcast.**
- **Healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.**

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