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, while a prisoner at HMP Highpoint

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 into the death of a man, who was found hanging at HMP Highpoint in September 2014 and died in hospital later that day. He was 26 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Highpoint was undertaken. The prison cooperated fully with the investigation.

The man was serving a 21 month sentence for theft and had been at Highpoint for just six weeks. He had been worried about his relationship with his girlfriend, losing his flat and whether he would be able to continue a plumbing course he had started in the community. He was therefore anxious to be released from prison early, under the Home Detention Curfew scheme. He had a history of depression and had harmed himself in the past.

In the two weeks before his death, the man's friends in his unit noticed that he seemed low and did not participate in activities he had previously enjoyed. He told them that his girlfriend had written and ended their relationship. Healthcare and prison staff knew that he was anxious about this and other matters, but did not consider him at risk of harming himself. Five days before his death, a doctor prescribed antidepressants at the request of a nurse, but did not see him himself. A mental health nurse saw him three days later. She assessed him as severely depressed, but also did not think he was at risk of harming himself as he appeared to be positively planning for his release.

One morning in September, the man spoke to his girlfriend and she reiterated that their relationship was over. A short time later, another prisoner found him hanging from the window bars in the shower room. After attempts to resuscitate him, paramedics took him to hospital. Doctors placed him on life support but found no brain activity. He died later that day.

I am satisfied that prison and healthcare staff, appropriately considered whether the man needed to be managed under Prison Service suicide and self-harm prevention procedures but concluded that he did not intend to harm himself. Sadly, with the benefit of hindsight, we know that this assessment was incorrect. However, I do not criticise the staff's judgement. Not everyone who is low in mood or depressed is at risk of suicide and it would have been difficult to predict or prevent his actions in September. However, the clinical reviewer raised serious concerns about the provision of mental health care at Highpoint, which we have been critical about before. A less pressed service, able to provide the level of care expected in the community, might have led to a more thorough multidisciplinary consideration of his risk and, possibly, a different outcome.

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 **June 2015**

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SUMMARY

1. On 30 May 2014, the man was sentenced to 21 months in prison. On 8 August, he transferred to HMP Highpoint from HMP Thameside. He had a history of depression and had harmed himself in the past. He asked to be referred to the mental health team for support.

2. The man was worried about his relationship, losing his flat and continuing a plumbing course. He was anxious to obtain Home Detention Curfew (HDC), when he became eligible in December 2014. Staff tried to support him, but, because of apparent staff shortages, his offender supervisor never met him to discuss the HDC arrangements.

3. On 28 August, a mental health nurse assessed the man and he talked about some of his problems. He said that he had last harmed himself three years ago, when he had cut his arm. The nurse did not consider that he needed to be supported by Prison Service suicide and self-harm prevention procedures (known as ACCT).

4. About two weeks before he died, other prisoners said that they noticed a change in the man's mood after his girlfriend had written and ended their relationship. He seemed down and spent a lot of time in his cell.

5. On 15 September, a doctor prescribed the man antidepressants and three days later, a mental health nurse assessed his depression as severe. As he had recently started antidepressants and spoke positively about the future, she concluded that he was not at risk of suicide or self-harm.

6. One morning in September, the man had run out of credit on his prison phone account and an officer allowed him to use an office telephone to phone his girlfriend, as he appeared upset. The officer was present during the call, when his girlfriend repeated that their relationship was over. After the call, he assured the officer that he was all right.

7. Some time after midday, the man told another prisoner that he was going for a shower. Not long afterwards, another prisoner found him hanging from the window bars in the showers. Staff responded quickly to an emergency call and tried to resuscitate him, until a doctor and paramedics arrived. Paramedics took him to hospital but he died later that day.

8. The man was evidently an anxious man and was receiving some mental health support. Although he had some problems, he appeared to remain hopeful and positive about his future. Staff who assessed him did not consider that he was at risk of suicide. While, ultimately, that judgement was wrong, we do not think that they could reasonably have foreseen or prevented his death. The clinical reviewer had some serious concerns about the mental health provision at Highpoint and we are critical about lack of contact from his offender supervisor and the lack of support for prisoners after his death. We make three recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Highpoint, informing them of the investigation and inviting anyone with relevant information to contact her. Two members of staff responded.

10. The investigator obtained copies of the man's prison and medical records and interviewed 12 staff and four prisoners at Highpoint. She informed the prison of the preliminary findings of the investigation.

11. NHS England commissioned a clinical reviewer to review the man's clinical and mental health care at the prison.

12. We informed the Coroner for Suffolk of the investigation and have sent him a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's sister and explained the investigation process. She asked what her brother had used to hang himself with and how he had reached the window bars. She said that the prison had told the family that he had showed no signs of depression before his death, but she knew that he had asked for help with his depression while at Highpoint.

14. The family appointed a solicitor to represent them who wrote to the investigator outlining the family's concerns about the telephone call the man made in September and the mental health provision at the prison.

15. The family received a copy of the draft report. During the consultation period, the family explained that he was not born in Holloway prison, nor did he live in a children's home, but he was adopted as an infant and did not leave home aged 15. The solicitor representing the family wrote to us with a number of other comments that do not impact on the factual accuracy of the report. We have provided clarification in separate correspondence.

HMP HIGHPOINT

16. HMP Highpoint is a medium security prison on two sites; Highpoint South which was the original HMP Highpoint and Highpoint North, which was previously known as HMP Edmunds Hill. Highpoint holds up to 1,325 men. The man was at the Highpoint North site. Care UK provides general and mental healthcare services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Highpoint was in September 2012. The Inspectorate found that, while there were some problems, the prison largely provided a decent and safe environment.

18. Inspectors noted that offender management was a concern. There was a good, decent strategy which was undermined by a lack of contact between prisoners and their offender supervisors. Inspectors concluded that the mental health services were adequate and patients felt supported. However, they recommended improved access to a range of support, including counselling and group therapies.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its latest annual report for 2013, the Board was concerned about the number of prisoners with severe mental health problems and that safer custody staff were often redeployed to other duties.

Previous deaths at HMP Highpoint

20. There have been seven other deaths at Highpoint since 2013, three of which were also self-inflicted. We have previously made recommendations about the prison's mental health service and we make a similar recommendation in this report.

Assessment, Care in Custody and Teamwork (ACCT)

21. 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 ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map 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 of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

HMP Thameside (May 2014-August 2014)

22. On 30 May 2014, the man was convicted of theft and sentenced to 21 months imprisonment, which he initially served at HMP Thameside. A nurse assessed him when he arrived. He told her that he had no history of alcohol or drug dependency, that he was fit and well and had no immediate issues or concerns. He said that he had no thoughts of suicide or self-harm and had never harmed himself before. She noted that he appeared to be mentally stable.

23. On 20 June, the man told a doctor that he had suffered depression since he was ten years old and, until two months earlier, had been prescribed 40mg of citalopram (an antidepressant) each day. He asked to re-start this medication and the doctor agreed to prescribe one month's supply of citalopram with a daily dose of 20mg.

24. On 23 June, the man told a nurse at a second health assessment that he had taken overdoses of his prescribed medication in 2010 and 2011 and had cut his wrists in 2012. He said that he had no current thoughts of suicide or self-harm and that he was taking antidepressants. The nurse referred him to the doctor.

25. On 3 July the man told a doctor that he did not feel depressed and had no thoughts of suicide or self-harm. He said that he had not been taking the antidepressants so the doctor stopped the prescription.

26. On 7 July the man told a nurse that he was having trouble sleeping and asked to be prescribed mirtazapine. She told him that mirtazapine was not prescribed for sleeping problems but was an antidepressant. He said his mood was fine so she advised him to exercise more and to try to relax. She advised him to consult healthcare staff again, if this did not help.

HMP Highpoint (August 2014-September 2014)

27. On 8 August 2014, the man transferred to Highpoint and a nurse assessed him in reception. He said he had no thoughts of suicide or self-harm, but asked to be referred to the prison's mental health team for support. She noted that he suffered from depression and said that he had taken an overdose four years earlier and cut his arms three years previously. She referred him to the mental health team who added him to their waiting list three days later.

28. The Governor received a letter dated 26 August from the man's MP, who wrote that he had contacted her about being assessed for HDC. She said he was keen to be released under the scheme as soon as he was eligible, because he wanted to retain the tenancy on his flat and complete a plumbing course. The prison replied on 2 September advising that the HDC process would begin on 23 September.

29. A mental health nurse met the man on 28 August for a mental health review. She told the investigator that she had noticed that his name had been on the mental health team's waiting list for a while, so she decided to see him. She said that the mental health team did not have a formal referral or allocation system at the time.

30. The man told the nurse that he had had a difficult childhood, a history of depression and had harmed himself in the past. She noted in his medical record that he had overcome self-harm and homelessness. He told here that most of his crimes had been in the context of trying to survive when he was homeless and he did not use drugs as both of his parents were heroin addicts. (He had been born in the mother and baby unit at HMP Holloway and lived in children's' homes until the age of 12 when he had been adopted and said he had experienced stability for the first time in his life. He had left his adoptive family when he was 15 because of behavioural problems and had been homeless for the next five years.)

31. The nurse noted that the man appeared low and fragile, but was helping himself in many ways and had a level of resilience and determination that helped keep him going forward. However, she noted that he was vulnerable to depression when he experienced loss or failure. He had been prescribed antidepressants in the past, including at Thameside, but had been reluctant to be prescribed them again. He said he would think about this. She did not note any assessment of his risk of suicide or self-harm at the time. She told the investigator that she had considered whether she needed to begin ACCT suicide and self-harm monitoring but concluded that she did not. She had discussed this with him, who was against the idea as it would have meant moving from his current unit for monitoring.

32. The man told the nurse that he had a plumbing apprenticeship in the community. He had completed level one of the course and had been accepted onto level two. He also hoped to complete a plumbing course at Highpoint. He said his priority was to obtain Home Detention Curfew (HDC). (HDC is a scheme which allows prisoners serving short sentences to be released early on licence with an electronic tag to monitor their compliance with residence requirements.) He would become eligible for HDC on 2 December, with the assessment process beginning on 23 September. She noted that he had agreed to remain on the mental health team's caseload and she recorded that she would see him again in two weeks. She told him that she would ask his offender supervisor when he would be considered for HDC.

33. A Senior Officer (SO) was the man's offender supervisor and told the investigator that he aimed to see prisoners within 10 days of their arrival at Highpoint and had hoped to see him within that timeframe. His last sentence plan was compiled on 21 July 2014. The SO said that he was not expecting to review the sentence plan until January 2015, six months after his previous review. However, because of staffing shortages, he was deployed to other prison duties, often covering for officers who were off sick, and did not meet him at all while he was at the prison.

34. On 3 September, the man submitted an application form, via the SO, for the Thinking Skills Programme as part of his sentence plan objectives. The SO forwarded the application to an administrator, who put the man on the waiting list. (He was later assessed as not meeting the criteria for the course.)

35. On 9 September, the mental health nurse noted in the man's medical record that she had tried to contact the SO about his HDC. The SO was not in the prison at the time and she noted that she would try again.

36. On 10 September, the man began a two-week Personal and Social Development class. The tutor described him as quite shy and timid, but said that he was hard-working and joined in smaller group discussions.

37. At 10.45am on 10 September, the man phoned his girlfriend. By the end of the call he had used up all of his phone credit and he did not buy any more credit before his death. He tried to make a number of calls after 10 September but none were connected because he had insufficient credit.

38. On 15 September, an officer, who was the man's personal officer, emailed the SO, to say that the man wanted to speak to him about his sentence plan. The SO replied that he would try to see him during the afternoon of 18 September.

39. On 15 September, when the man arrived at his class, he asked the tutor if he could go to the healthcare centre. She said that he should have asked a prison officer before he left the unit and he looked upset. He became tearful and said that he was not coping. Because of this, she agreed that he could go to the healthcare centre.

40. A nurse saw the man in the healthcare centre. He was tearful and said that he had not been sleeping because he was worried that he might not get HDC and would lose his flat. She said that he spoke a lot about his plans for the future, so she was not concerned that he was at risk of suicide or self-harm. He agreed to her suggestion that he should start taking antidepressants again and she said she would ask the mental health nurse to see him. She spoke to a doctor, who prescribed citalopram (20mg each day) and Nytol tablets (a herbal sleeping aid). The doctor did not examine him before prescribing the medication and the nurse did not record details of her consultation with him in his medical record until the next day.

41. On 16 September, the man went to his class and told the tutor he was feeling much better. Later that day, he went to an employment fair at the prison. He spoke to a careers advisor about an application he had made at Thameside to begin a distance learning plumbing course. She said she would find out the status of his application.

42. On 18 September, the mental health nurse saw the man and noted that he had started citalopram. He was still worried about losing his flat and was concerned that his girlfriend who was looking after it for him was finding it difficult to manage. She said she would contact Nacro (a voluntary

organisation which provides resettlement advice and support to offenders) to see if they could help him.

43. The mental health nurse recorded that the man had said that he sometimes thought he would be better off dead but he had no plans to harm himself. She assessed him as at low risk of suicide or self-harm and noted that he still had hopes for his future. He said he did not want wing staff to know how he was feeling, but said he would talk to Listeners (prisoners trained by the Samaritans to support other prisoners) and call the Samaritans if he needed to. He said his adoptive parents and his girlfriend supported him. He said that he was also in contact with his birth mother.

44. The mental health nurse completed a PHQ9 risk assessment, which assesses levels of depression from zero (no depression) to 27 (severe depression). The man scored 26, which indicated severe depression. She told the investigator that prisoners often score highly. She said that, in her view, they were already managing his depression by prescribing antidepressants and trying to sort out the underlying reasons for his depression.

45. One of the questions on the assessment asks how often the individual has had thoughts that they would be better of dead or of hurting themselves in some way. The man responded that he had felt like this on more than half of the days in the last two weeks. Against this, the nurse said that he had definite plans for the future and the support of his family and she thought that his mood had improved since their last consultation. She did not begin ACCT suicide and self-harm monitoring for these reasons and because he had been reluctant to consider an ACCT previously. She did not record details of her considerations in his medical records.

46. The nurse told the man that she had spoken to his offender supervisor and he knew the man was worried about losing his home. She said that she thought it was unlikely that an eviction order would be obtained before he was released on HDC, but that the SO would speak to him about this. The SO had to work in another part of the prison and did not meet him that day as he had said that he would try to do.

47. Later on the 18 September, the careers advisor told the man that he had been accepted for the plumbing course at the prison. He told her about his housing situation and that he was worried that his girlfriend had not been able to pay all of the rent. She knew that he was in contact with a housing advice worker and reassured him that he was in good hands. She said he should begin the plumbing course soon, and he seemed happy about this.

48. The mental health nurse telephoned the housing advice worker on 18 September. She told her that the man was worried that he would lose his flat while he was in prison. The housing advice worker went to see him in his class that day to discuss his housing worries.

49. The man told the housing advice worker that he thought he had received a breach of contract letter from his landlords and that his girlfriend was trying to

sort this out. She said she would need to see the letter and asked him to bring it to a meeting with her the next day. He wanted to go to the gym the next day, so they arranged to meet on the morning of 22 September.

50. A prisoner and friend of the man's recalled that sometime during this week, the man had received a letter from his girlfriend. He did not show the prisoner the letter, but told him that things were not good between them. He said that the man seemed very low in mood after he got the letter. He had also told the prisoner he was worried about his HDC. The prisoner said that the man had asked whether he could be considered for HDC a few weeks earlier than scheduled, as he wanted to attend a course in the community.

51. Another prisoner said that he knew the man quite well. He played cards, went out for exercise and to the gym with him. He said that the man had seemed down in the two weeks before his death. He was not so interested in going to the gym and spent a lot of time in his cell. The man had told him that he had some issues with his girlfriend and had received a letter from her. He asked the prisoner for some stamps so he could write letters, although he did not say who he was writing to. The prisoner described him as quite an emotional person, but neither he nor the other prisoner had ever thought that he might harm himself.

52. An officer knew the man quite well and had spoken to him several times about his problems, including his relationship with his girlfriend. The officer said he was someone who needed a lot of support, but he always seemed reassured after talking things through. The officer said that he had no concerns that he would harm himself.

Day of the incident

53. On the day of the incident prisoners on Unit 13 (where the man lived) were unlocked at around 8.40am. He collected his breakfast, but said he was not very hungry and offered it to his cellmate. The cellmate asked him what was the matter and he started to talk about his girlfriend and a letter he had received a week or so earlier suggesting they break up.

54. The man and a prisoner went outside to the exercise yard together at about 10.30am. At about 11.30am, he asked Officer A if he could use an office phone because he did not have any credit left on his prison phone account and he wanted to speak to his girlfriend. The officer discussed this with Officer B, the man's personal officer, and they agreed that because he appeared genuinely agitated, they would allow him to use the office phone. Officer B said that she knew he was likely to be granted HDC in December and that he was concerned about losing his flat and had problems with his girlfriend.

55. Officer A dialled the number for the man and then sat next to him while he spoke to his girlfriend. The officer said that the call lasted over five minutes and that he could only hear the man's side of the conversation. At first, he spoke about their future and their relationship, but it soon became clear that

his girlfriend had decided to end their relationship. The officer said that he told his girlfriend that he would change and became agitated and tearful. Eventually he slammed down the receiver.

56. Officer B asked the man if he was all right and he said he was. He said that he saw him at least twice more that day and each time, he asked how he was feeling. He said that the man had told him he was okay. The officer said that he seemed more angry than upset at the end of the call. He did not think that he was at risk of suicide or self-harm. Due to staff shortages, officers locked the unit up at approximately 11.45am, after serving lunch. The officers were on their lunch break from that time. The unit consists of several spurs of cells with communal shower rooms also containing toilets and washbasins. The gates onto each spur were locked leaving prisoners free to move around each spur while officers were at lunch.

57. At about midday, the man spoke to a prisoner about the phone call. He said that his girlfriend had said that their relationship was over and they would not be getting back together.

58. The man spoke to another prisoner a few minutes later. He told the prisoner that his girlfriend had ended their relationship and had moved her belongings out of their flat. The prisoner said that he asked him if he was okay and he replied that he would just have to get on with things. He rolled a cigarette and they talked for a while. He then said he was going for a shower. On the way, he asked another prisoner for a light for his cigarette. He went into the showers and shut the door.

59. The prisoner said that he had shouted to the man while he was in the shower room to ask whether he had his DVD player. He said that he had, and that he would take it round to him later. Another prisoner overheard this exchange.

60. A few minutes later, at approximately 12.30pm, a prisoner went to use the toilet in the shower room. He said that he was washing his hands when he noticed a towel and a half-smoked cigarette on a chair. He thought it was strange that there was no sound of anyone having a shower when the man had gone for one.

61. The prisoner walked around to the shower area and saw the man, suspended by a strip of orange blanket which was tied to the window bars. He shouted for help and pressed the alarm bell. Control room staff recorded this at 12.36pm. He said that he did not know what to do, but two other prisoners arrived almost instantly.

62. A prisoner had heard the call out and he and another prisoner ran into the showers. One prisoner supported the man's weight by lifting his legs while another tried to untie the ligature. (The window was low enough for him to do this.) The prisoner said that it took him about 20 to 30 seconds to untie the knot and then they lowered the man to the floor.

63. Officer B and Officer C were in an office on the floor below when they heard shouting, then a general alarm bell in quick succession. A prisoner also rang his cell bell. They ran up the stairs and to the shower room as prisoners shouted to tell them what had happened.

64. Officer B saw the man lying on the bathroom floor with prisoners standing around him. She checked him for signs of life. She found no pulse and he was not breathing so she began cardiopulmonary resuscitation by giving chest compressions and rescue breaths. At 12.37pm, Officer C radioed a code blue emergency (used to indicate emergencies such as when a prisoner is not breathing). At 12.38pm, control room staff called an ambulance.

65. Officers heard the emergency call and arrived within a minute took over the resuscitation attempt from Officer B.

66. Two nurses were in the healthcare centre when they heard the code blue. They said that it took them approximately two minutes to reach the man and they continued with the emergency treatment. Nurse A brought an emergency bag, which contained a defibrillator (a life saving device that gives the heart an electric shock in some cases of cardiac arrest). She applied this to his chest but it found no shockable heart rhythm. Nurse B inserted an airway attached to an Ambu-bag (a manual resuscitator) to administer breaths.

67. An ambulance arrived at Highpoint at 12.57pm and paramedics reached the man a minute later and took over from the healthcare staff. An on-call intensive care unit consultant arrived by car and administered a shot of adrenalin three times to stimulate his heart.

68. The paramedics requested an air ambulance, but as there was nowhere for it to land, they decided to take the man to hospital by ambulance. The ambulance left Highpoint at 2.20pm. Two officers and the intensive care consultant went with him.

69. At hospital, the man was placed on life support. Shortly after, a doctor told the officers that a brain scan had showed no brain activity and wanted to discuss the possibility of organ donation.

Contact with the man's family

70. An officer acted as the prison's family liaison officer. At 2.40pm, she phoned the man's girlfriend, who he had listed as his next of kin. She explained what had happened. The man's girlfriend said that she would tell other family members and would go the hospital. An hour later, the man's sister telephoned and the officer explained the situation. His family arrived at the hospital at approximately 7.45pm.

71. The man was pronounced dead at 9.45pm and his family gave permission for organ donation. The prison contributed to the cost of the funeral in line with national guidelines.

Support for prisoners and staff

72. A prisoner said that he found it hard to sleep after the man died, but no one offered him any specific support or advised him that he could speak to Listeners or the Samaritans. None of the prisoners on the unit were subject to suicide monitoring procedures at that time, but staff offered them the opportunity to speak to a chaplain. Another prisoner said that he felt staff could have given prisoners more support. He said that he had to ask who he could speak to about the man's death. He had written down the names of other prisoners who he thought might be affected and passed them to healthcare staff.

73. At 2.15pm, a prison manager held a debrief meeting for staff involved in the emergency response and the prison's care team offered staff support. A manager spoke to the two officers who accompanied the man to hospital when they arrived for work the next day and offered them support if they needed it.

Post-mortem

74. A post-mortem, carried out on 22 September 2014, determined that the man died of hypoxic brain injury because of hanging. A toxicology report found that he had no alcohol or drugs in his body at the time of his death

ISSUES

Assessing the man's risk of suicide and self-harm

75. Prison Service Instruction (PSI) 64/2011, which governs ACCT procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. It also identifies that any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Highpoint should have identified the man as at risk of suicide and self-harm and opened an ACCT.

76. The PSI lists a number of risk factors and triggers, several of which applied to the man, including a troubled childhood, a history of self-harm, depression and relationship instability / breakdown.

77. On 18 September, a mental health nurse carried out the Patient Health Questionnaire (PHQ-9), a tool used to monitor severity of depression and response to treatment. The man scored 26 out of 27 indicating severe depression. She said that she had considered beginning ACCT procedures, but concluded that it was not necessary. She assessed him as a low risk for acting on any thoughts of harming himself. He said that he did not want wing officers involved and that he had the support of his adoptive parents and his girlfriend. He was now taking antidepressants and was hopeful for his future. She thought he had seemed better than when she had seen him on 28 August and she did not think he was at risk of harming himself. She reassured him that his HDC was more dependent on his good behaviour than active involvement from his offender supervisor and that it was unlikely that the council would be able to obtain an eviction order before he was released and able to regain possession of his flat. She told him that she had spoken to his offender supervisor about this, and he was aware of the position. After the consultation, she followed up his concerns, including talking to his housing worker who went to see him later that day.

78. Around an hour before he was found hanging, the man spoke to his girlfriend from the unit office phone and she repeated that their relationship was over. Officer A was present during the conversation and knew that he was upset and angry. However, he maintained that he was all right. The officer and other prisoners, who spoke to him afterwards, knew he was upset but saw nothing which made them concerned that he intended to harm himself.

79. It is unfortunate that the mental health nurse could not discuss her assessment on 18 September, with a properly functioning mental health team (discussed below). As she had to make her decision in isolation, it might have been prudent to have opened an ACCT. However, staff judgement is fundamental to the ACCT system. It relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. We are satisfied that the mental health nurse appropriately considered whether to open an ACCT and used her clinical judgement to conclude that he was not such a risk that he needed to be monitored at the time. She could not have

anticipated the telephone call with his girlfriend which had increased his vulnerability and we do not criticise her decision. Nor do we consider that Officer B had sufficient reason, after the telephone call, to conclude that he needed to open an ACCT.

Mental health care

80. The clinical reviewer found that the mental health care delivered to the man by Highpoint was flawed and not equivalent to that he could have expected to receive in the community. He noted that, in the community, a GP would have referred him to a Community Mental Health Team which would have triaged the referral and he would have been seen by members of staff who were supported and supervised. He was concerned that mental health nurses at Highpoint had to act alone and unsupervised without the support of a team to reflect on practice. They were overwhelmed by the increasing number of referrals.

81. The clinical reviewer noted that, at the time of the man's death, there was no mental health team leader. There was no formal referral process to the team and prisoners were added to a list and seen randomly. There was no distinction between primary mental health care and prisoners with severe and enduring mental health problems and there were no regular team meetings. Several mental health staff had left and, by August 2014, remaining members of the team were struggling to cope with the workload without leadership and support.

82. While the mental health nurse gave the man some caring and effective help, within the constraints of the service available at Highpoint at the time, the investigation identified several failings in his mental health care, including:

- A 20 day delay between the reception nurse referring him to the mental health team and him being seen by the mental health nurse, due, at least in part, to the absence of proper referral and allocation systems.
- Nurses did not record full details of their consultations with him promptly.
- He never saw a GP at Highpoint and a doctor prescribed him antidepressant and sleeping medication without examining him and without arranging a review appointment.
- Mental health nurses had no one to discuss their assessments of him with and no clinical supervision to support them.
- The mental health nurse arranged to review him two weeks after a PHQ-9 depression assessment, which indicated that he was suffering severe depression. This was too long.

83. The clinical reviewer escalated his concerns to the Head of Health and Justice in the East Anglia Area Team of NHS England as he was concerned that the mental health service provided at Highpoint was unsafe. Following this, we understand that some improvements were made including the appointment of a team leader and the introduction of a new referral system. He has made

some wide-ranging recommendations which the Head of Healthcare will need to address. We make the following recommendation:

The Head of Healthcare should ensure that there is a fully staffed mental health team which meets the needs of prisoners at Highpoint, with appropriate referral processes, discussions of all new referrals at regular multidisciplinary team meetings and the opportunity, after a consultation, for staff to discuss their findings with a senior member of the mental health team.

Contact with offender supervisors

84. A SO was appointed as the man's offender supervisor around 28 August. He was frequently deployed to work in other parts of the prison because of staff shortages. In fact, the SO Feeney never met the man, despite several other staff contacting him about his anxieties about the HDC process.

85. HM Inspectorate of Prisons noted in their 2012 inspection that the role of offender supervisors was both unclear and variable. There was no agreed policy relating to the frequency of contact for high-risk prisoners, no planned or structured appointments with prisoners and no one-to-one work being undertaken. Planned contact for those assessed as lower risk was limited to an annual review. We note that the SO said he planned to see the man six months after his sentence plan targets had been set. Had he not been released on HDC, this would have been approaching his potential release at the half–way point of his sentence and possibly too late for appropriate input into sentence planning to improve his chances of release and effective resettlement. We make the following recommendation:

The Governor should ensure that offender supervisors meet all prisoners they are responsible for shortly after their arrival to assess their immediate needs and have sufficient allocated time for regular agreed contact thereafter to help prisoners achieve their sentence plan objectives and coordinate effective resettlement.

Support for prisoners

86. Some prisoners we spoke to said they experienced a lack of care and support after the man's death. This included those who were closely involved with finding him hanging and it is concerning that no one appears to have identified that they might need targeted individual support. We make the following recommendation:

The Governor should ensure that after a prisoner dies, prisoners who were close to him or involved in the emergency response are informed of the death personally and offered appropriate individual support.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there is a fully staffed mental health team which meets the needs of prisoners at Highpoint, with appropriate referral processes, discussions of all new referrals at regular multidisciplinary team meetings and the opportunity, after a consultation, for staff to discuss their findings with a senior member of the mental health team.

2. The Governor should ensure that offender supervisors meet all prisoners they are responsible for shortly after their arrival to assess their immediate needs and have sufficient allocated time for regular agreed contact thereafter to help prisoners achieve their sentence plan objectives and coordinate effective resettlement.

3. The Governor should ensure that after a prisoner dies, prisoners who were close to him or involved in the emergency response are informed of the death personally and offered appropriate individual support.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that there is a fully staffed mental health team which meets the needs of prisoners at Highpoint, with appropriate referral processes, discussions of all new referrals at regular multidisciplinary team meetings and the opportunity, after a consultation, for staff to discuss their findings with a senior member of the mental health team.	Accepted	The Head of Health Care (HC) has written a new Mental Health Pathway (MHP) which covers all the issues raised in recommendation 1. This was presented at a NHS Contract Meeting 25 March 2015. The aim is for this to be ratified at the next NHS/HMP Partnership Board Meeting in June. A review of staffing resources was completed and forms part of the MHP. The outcome of the review was that the new provider has employed staff dedicated to Highpoint in sufficient numbers to deliver the service required. The Clinical Review for the man was circulated to the Head of HC and the recommendations have been added to the HC consolidated action plan. Progress in this area will be presented to NHS England monthly for them to monitor.	Target date for completion: 30th June 2015 Head of Health Care / NHS England	
2	The Governor should ensure that offender supervisors meet all prisoners they are responsible for shortly after their arrival to assess their immediate needs and have sufficient allocated time for regular agreed contact thereafter to help prisoners achieve their sentence plan objectives and coordinate effective resettlement.	Accepted	All prisoners are seen by the Offender Management Unit (OMU) on their initial reception into the establishment. A review will now take place to consider and address the issues raised in recommendation 2. The review will consider all factors that impact on our service delivery in this area and form conclusions and recommendations for improvement. Our aim will be to have an agreed timeframe in which prisoners should expect to be seen by their Offender Supervisor, who will assess their immediate needs and arrange to have regular time allocated with the prisoner to help them achieve their sentence plan objectives and co-ordinate effective resettlement for them.	Target date for completion30th July 2015 Head of Offender Management Unit (OMU)	
3	The Governor should ensure that after a prisoner dies, prisoners who were close to him or involved in the emergency response are informed of the death personally and offered appropriate individual support.	Accepted	The Head of Residence (South) in partnership with the Chaplaincy Department will draft a local policy advising of the procedure to follow after a prisoner dies. The policy will identify the support options available to individuals close to the deceased and those involved in the emergency response at the time. Once agreed, the policy will be published and advertised appropriately. To	Target date for completion: 1 May 2015 Head of Residence South and Head	