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 November 2014, while a prisoner at HMP Humber

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 died in November 2014 after he had hanged himself in his cell at HMP Humber four days earlier. He was 32 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received whilst in prison was undertaken. HMP Humber cooperated fully with the investigation.

The man was released from a prison sentence on licence in September 2012 but was recalled to prison in October charged with further offences. In May 2013, he was sentenced to five years in prison. Staff assessed him as at risk of suicide and self-harm several times and he moved to the Wolds site at Humber in July 2014 after saying that he did not feel safe at HMP Dovegate. At Humber, he began a railway workers' training scheme but started not to attend. On Friday 14 November, he told a mental health nurse that other prisoners were pressuring him to collect packages thrown over the prison wall. He also said he had been taking drugs. The nurse reported the concerns to the security department. He asked to move from his wing. It was agreed that he would move to the Everthorpe site of the prison, but this did not happen.

On Friday 21 November, the man took an overdose of paracetamol and codeine and was treated in hospital. He said that he had meant to die because he felt unsafe on his wing. When he returned from hospital, staff told him that he would be moved to the Everthorpe site the following Monday, but he had not moved by lunchtime on Monday. In the early afternoon, an officer found that he had covered the observation panel in his cell and she was unable to check his welfare. She went to get help and five minutes later, officers opened the cell and found he had hanged himself. He died in hospital a few days later.

The man had reported feeling isolated and said that he was being pressured by other prisoners to collect contraband. I am concerned that the prison did not organise a move to the Everthorpe site, as originally planned, to get him away from that pressure. When he took an overdose, staff appropriately began suicide and self-harm prevention procedures and again promised to move him to the Everthorpe site. There was a lack of clarity about who was responsible for this and I do not consider that the need for a move was given sufficient priority or that staff fully understood how this affected his risk of suicide and self-harm. I am also concerned that, as he had been identified as at risk of suicide, it took too long to open his cell after he had covered the observation panel and did not respond.

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. The man was recalled to prison on 12 October 2012, after being released on licence from a sentence a month before. Initially, he was held at HMP Birmingham and then transferred to HMP Dovegate on 21 March 2013. On 21 May 2013, he was sentenced to five years imprisonment for burglary and driving offences. He transferred to the Wolds site of HMP Humber on 18 July 2014.

2. After the man's sentence, prison staff managed him under Prison Service suicide and self-harm prevention procedures, known as ACCT, four times. He often said that he did not feel safe in prison. On 14 November 2014, he told a member of the mental health team that other prisoners were pressuring him to collect packages of illicit items thrown into the prison. Prison staff agreed that they would move him to the Everthorpe site of the prison, but this had still not happened a week later. On Friday 21 November 2014, he took an overdose of tablets and said he wanted a move. At hospital, he repeated that other prisoners were threatening him. Staff monitored him under ACCT procedures and, at a review on Saturday, decided he should move to the Everthorpe site the next Monday.

3. On the morning of Monday 24 November, the day of the proposed transfer, the man was upset that he had not yet moved and staff gave him no assurance this would happen. At about 2.20pm, an officer found that he had covered the observation panel in his cell door and did not respond to her. She went to get help from other officers but, when they went in to the cell five minutes later, they found he had hanged himself. Officers and healthcare staff performed cardiopulmonary resuscitation until paramedics arrived. Paramedics took him to hospital but he never regained consciousness and he died a few days later.

4. Prison staff appropriately opened ACCT procedures after the man took an overdose but we are concerned that the action to move him to the Everthorpe side of the prison was not given sufficient priority, either after the ACCT was opened or a week earlier, when he had first reported being threatened. Staff did not appear to have fully understood the effects of his situation on his risk of suicide and self-harm. Once the officer found that he had covered his cell observation panel, it took too long to get into his cell. We make three recommendations.

THE INVESTIGATION PROCESS

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

6. The investigator visited Humber on 9 December, and obtained copies of the man's prison and healthcare records. NHS England appointed a clinical reviewer to review the man's clinical care. The investigator and clinical reviewer interviewed 13 members of staff at Humber on 6 and 7 January 2015.

7. The investigator informed HM Coroner for East Riding of Yorkshire of the investigation. We have sent the coroner a copy of this report.

8. One of the Ombudsman's family liaison officers contacted the man's family to inform them of our investigation and to invite them to identify any relevant issues they wanted the investigation to take into account. They asked us for details of the emergency response and had a number of questions, including the following:

    - Had he been bullied?
    - Was he on suicide watch?
    - What information did staff give him about his transfer?
    - What had he used as a ligature?

HMP HUMBER

9. HMP Humber was formed by the amalgamation of two adjacent prisons, HMP Wolds and HMP Everthorpe. The prison currently operates separate regimes on the two sites. It holds up to 1062 prisoners. The man lived on the Wolds site, which holds up to 395 adult male prisoners aged over 21 years, who are serving medium to long-term sentences. Healthcare services are provided by Humber NHS Foundation Trust.

HM Inspectorate of Prisons

10. HM Inspectorate of Prisons has not yet inspected Humber. The last inspection of HMP Wolds was in April 2012, a follow up of a full inspection in 2010. At the time, inspectors found that the violence reduction strategy was comprehensive and complemented by an antisocial behaviour and bullying policy. Inspectors described support for prisoners at risk of suicide and self-harm as good. Security arrangements were proportionate, but inspectors found that illegal drug use was high and the prison did not give enough attention to illicitly traded prescription medication.

Independent Monitoring Board

11. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In the last IMB annual report for HMP Wolds, for the year to May 2013, the IMB was satisfied that the prison was managed well and that prisoners were treated with dignity and respect. The IMB noted that despite significant improvements in preventing illicit substances entering the prison, screening for 'legal highs' remained a challenge.

ACCT - Assessment Care in Custody and Teamwork

12. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at Humber

13. Since 2004, there has been one self-inflicted death at the Wolds site which occurred in 2009. There have been three self-inflicted deaths at the Everthorpe site, one in 2006, and two in 2014. In our report into the last death at the Everthorpe site, we made recommendations about the operation of ACCT and emergency response procedures. We discuss these issues in this report.

KEY EVENTS

14. The man had a number of convictions dating back to 1996, and had previously been in prison. He had a history of drug use, and there was security information that he had bullied other prisoners, was often in debt and was violent towards other prisoners and staff.

15. The man was released on licence from a prison sentence on 21 September 2012. On 12 October 2012, his licence was revoked and he was recalled to prison after being charged with offences of burglary and driving while disqualified. He was sent to HMP Birmingham. On 21 March 2013, he was convicted and moved to HMP Dovegate. On 21 May 2013, he was sentenced to five years in prison. In 2012 and 2013, he was prescribed mirtazapine, an antidepressant. He was last prescribed this in July 2013.

16. Staff managed the man under ACCT procedures three times while he was at Dovegate. (He had not been identified as at risk of suicide and self-harm during previous sentences.) The first time was on 7 June 2013, when he put razor blades in his mouth and threatened to swallow them because he did not want to transfer to HMP Stoke Heath. He said he had issues with prisons in the Midlands and his family had been threatened. He said he would move anywhere outside the Midlands. Officers closed the ACCT on 14 June. In November 2013, he moved to the therapeutic community at Dovegate, which is run on psychotherapeutic principles, where prisoners are expected to be open about and discuss their offending behaviour.

17. On 18 June 2014, staff opened an ACCT when the man said he was finding it difficult to cope, after his uncle had been diagnosed with cancer and his father had been assaulted. He said he felt guilty that he was not there to support them. He did not harm himself. Officers closed the ACCT on 9 July.

18. The third ACCT at Dovegate was opened on 17 July, when the man indicated he might cut his wrists. He said he did not feel safe, was struggling to stay off drugs and thought he was being forced to say things in therapy sessions that he did not want to. He said that he wanted to transfer to another prison and was taken to the segregation unit. During an ACCT assessment interview, he said that some prisoners in the therapeutic community were blaming him for recent security searches and were calling him a “grass”. Others had blamed him for another prisoner ending up in hospital after taking drugs. He said that he was disappointed that he would not complete the therapy, but needed to move.

19. A custodial manager chaired a case review on 18 July, and completed an ACCT caremap with one action: to organise a transfer for the man. A senior therapist at Dovegate arranged for him to move to HMP Humber later that day. The custodial manager noted on the ACCT document that the next review should take place on 19 July, after he arrived at Humber.

20. On 19 July, at Humber, a Supervising Officer (SO) chaired an ACCT review. The man said he had manipulated the ACCT system to ensure he got a transfer from Dovegate because there were so many drugs there and he wanted to stay drug-free. He said that he had never had any thoughts of suicide or self-harm. He wanted a prison job and to work towards moving to an enhanced level wing

to ensure that he remained drug free. The SO closed the ACCT as the caremap had been completed and he was satisfied that the man was not at risk of suicide or self-harm. Another SO completed the post-closure interview on 26 July, and recorded that the man had no issues and was happy to be at Humber.

21. The man worked in a railway training facility at Humber, which gives prisoners skills for jobs on the national rail network. He lived in a double cell by himself on C Wing, on the Wolds site.

22. On 11 August, the man discussed his move from Dovegate and his reasons for coming off mirtazapine in 2013, with a mental health triage nurse. He said that mirtazapine had not helped him, except to sleep. He said that he was not sleeping well, had lost his appetite, felt isolated and had panic attacks before going out for exercise periods in the open air. He said that several family members were ill, and his grandmother had recently died. She referred him for a full mental health assessment as she thought he might have symptoms of depression.

23. The man injured his back while weightlifting in August 2014. On 22 August, a prison GP, prescribed codeine to relieve the pain, but they did not discuss his mental health. He later received physiotherapy for his back problem.

24. On 22 September, the man discussed his recent bereavements with a member of the mental health team. He said that he was struggling to come to terms with his losses. However, he also felt reassured that he was able to talk to the chaplaincy team. She agreed to take him onto the mental health team caseload for short-term support.

25. On 13 October, the man told his personal officer that he did not want to be associated with other prisoners on his wing and wanted to move. He said that he wanted this to be his last prison sentence as he wanted to be a proper father to his son. She told him that he might be able to move to D Wing when there was space.

26. On 17 October, a nurse from the mental health team reviewed the man and recorded that he was in low mood and had been unhappy on C Wing for a while, as he did not have any support from other prisoners on the wing. She agreed to speak to prison staff to discuss a move from C Wing. She said that they should meet regularly and she would book an appointment for him with the GP to discuss medication.

27. On 20 October, a nurse spoke to an officer about arranging a move for the man. The officer recorded in his case notes that he had arranged a cell on D Wing for him. However, the man's personal officer told the investigator that he then chose not to move and said he wanted to stay on C Wing.

28. The personal officer told the investigator that the man went to work each day and was looking forward to getting a job on the railways when he was released. She said that he was pleased that he and his mother had successfully got custody of his child. Staff had arranged for him to speak to social services and she said that he seemed positive about his future.

29. On 27 October, the man discussed his bereavements and childhood trauma with a doctor. The doctor recorded that he was angry, tearful, lethargic and hopeless but said that he did not have any thoughts of self-harm. The doctor diagnosed depression and prescribed venlafaxine, an antidepressant.

30. The investigator listened to the last two phone calls the man made, which were to his mother on 7 and 15 November. In the first call, he appeared in good spirits and he spoke to his son and other relatives as well as to his mother. He said that he had only seven months left of his sentence and could not wait to be with them all. During the second call, he spoke to his sister and asked her for £25. He said his cellmate had been released and had left him in trouble. His sister said no one could send him any money.

31. On 11 November, the man's offender supervisor, (responsible for the oversight of his sentence plan in prison) held a telephone conference with the man and his offender manager (probation officer). They agreed that they would not recommend him for security category D (which would have meant he would be eligible to transfer to an open prison) despite his improved behaviour and motivation to address his offending behaviour. The offender supervisor recorded that the man was upset about this and said that he felt that he had been treated unfairly by probation staff in the past. The offender supervisor recorded that he had told the man's personal officer about this conversation and had asked her to monitor his behaviour in the coming days.

32. On Friday14 November, the man went to the healthcare centre and asked to see someone from the mental health team. A nurse agreed to see him. He told the nurse that he felt low, and had not seen any of his family for over a year as he was so far from home. He admitted that he had been taking illicitly obtained subutex (an opiate substitute) and 'Mamba' (a synthetic cannabinoid, known as a new psychoactive substance). He said he kept to himself on the wing, but that other prisoners often came into his cell and just stared at him before leaving again. (It is not clear what he meant by that.) He also said that he was getting into debt.

33. At this point, the man asked the nurse if he could go back to the wing to call his mother. They agreed to meet again later. The nurse recorded in his medical record that he had contacted wing staff to ask them to keep an eye on him and to tell them that the man would be coming back to see him later. However, he did not return. His personal officer noted in his prison record that he had seemed quite down, but that he had not been able to go back to see the nurse because issues within the prison had prevented this. The records do not identify what these issues were.

34. The nurse told the investigator that the man appeared low in mood, but had spoken about his child and his future when he left prison, the following July. He had told him that the railway training programme was near a wall where packages containing illegal substances were thrown into the prison. He said that other prisoners were pressurising and threatening him to collect these packages. Because of this, he did not want to go to work.

35. The nurse said that he had got someone from the security department to speak to the man that afternoon. He said that the man was told that it would be possible to move him over the weekend, but this was unusual and might arouse

suspicions. He had therefore reluctantly agreed to wait until Monday, when it was planned he would moved to the Everthorpe site. The nurse had also spoken to his training programme mentor, who was concerned about him. The nurse said that the man did not appear to have any suicidal ideation and he did not have any concerns about him harming himself.

36. On Monday 17 November, a doctor reviewed the man and recorded that he had been taking venlafaxine for three weeks and had not had any side effects, but also no substantive change in his mood. The doctor noted that he made poor eye contact and was flat in mood but had no thoughts of suicide. The doctor maintained his prescription at the same level, and planned a review four weeks later.

37. While he was in the healthcare centre, the man spoke to a nurse about the proposed move, which had not taken place. The nurse checked with another nurse, who told her that the plan had been to move him to the Everthorpe site. The nurse told the investigator that he had spoken to the OCA (Observation, Classification and Allocation department, responsible for transfers) and the security department several times that week about the move to the Everthorpe site. On Wednesday 19 November, the OCA had told him that the man would move on Thursday 20 November. However, the move did not take place.

38. On the morning of Friday 21 November, the man went to the healthcare centre, without an appointment, and saw a nurse. He said that the threats from other prisoners on the wing had got worse and he was worried about his safety. The nurse arranged to see him later that afternoon and recorded that that she would speak to another nurse and the security department about his move.

39. The man went back to the healthcare centre that afternoon. The nurse recorded that he appeared sleepy, unsteady on his feet and was slurring his words. He said that he had taken an overdose of paracetamol and codeine, as he had felt unsafe on his wing. He said that he intended to take his life, as officers had told him that he did not have a mental health appointment that afternoon and he did not think that he would be disturbed. The nurse opened an ACCT and he was taken to hospital.

40. A manager completed an ACCT immediate action plan and set the level of observations at five each hour. (The local policy at Humber is that the level of observations is always initially set at five an hour when an ACCT is first opened.)

41. At the hospital, the man told one of the officers escorting him that two prisoners had threatened him on the wing and had asked him to collect a parcel that was going to be thrown over the prison wall. (There is nothing to indicate that anyone passed this information to the security department.) After tests at the hospital, officers took him back to the prison, as he did not need any treatment. He arrived back at 10.10pm, and went to A Wing.

42. On Saturday 22 November, at 10.40 am, an officer interviewed the man for an ACCT assessment. The officer told the investigator that he had read his prison records and had spoken to a nurse before he saw him for about 40 minutes. He refused to come out of his cell as he said he did not feel safe as C Wing prisoners had threatened him. He said he wanted a transfer to another prison.

He thought that he had been promised a move, but this promise had not been honoured.

43. At 2.20pm, a custodial manager and a nurse held the first ACCT case review in the man's cell, as he still refused to come out. The custodial manager wrote one caremap action - for him to be transferred to the Everthorpe site, "at [the] first opportunity". The prison department responsible for organising prisoner moves (the OCA - Observation, Classification and Allocation department) was noted on the caremap to be responsible for this action. They assessed his level of risk as unchanged, but they reduced the level of observations to three an hour at all times. They scheduled the next case review for 26 November.

44. The custodial manager told the investigator that he had told the man that he would be moved to the Everthorpe site on Monday, as movements do not take place at the weekend and he said he understood this. The custodial manager said, as no one had any specific concerns that he was at imminent risk of harming himself, he and the nurse agreed that it was appropriate to reduce the level of observations to three per hour.

45. On Sunday 23 November, the nurse saw the man twice, in the morning and the afternoon. She told the investigator that both times he was in a positive mood and looking towards his release and being with his son and family. He talked about finding a job, and said he had no thoughts of suicide or self-harm.

46. On Monday 24 November, an officer recorded in the ACCT document that she saw the man collect his meal at 12.10pm and he had said that he would smash his cell if he did not move to the Everthorpe site that day. She told the investigator that she had told him that while a move might take place that day, she could not be sure about this.

47. The officer checked the man again at 12.30pm, and 12.50pm, and both times she noted that he was sitting on his bed watching TV. When she went to do another ACCT check at 1.10pm, the wing was in patrol state (when all prisoners are locked in their cells with minimal staff on duty). She was alone on the landing and found that he had covered the observation panel in his door with a towel.

48. The CCTV footage of the wing shows that the officer looked down the edges of the cell door and then walked away. She said that she could not see into the cell and later wrote in the ACCT document that she had been unable to get a response from the man. She believed that she could not open the cell and go in without someone else being present. She had a radio but did not use it. Instead, she went to the staff room on the top landing as she knew there were officers there on their lunch break, who would be able to help her open the cell and phoned the orderly officer (the manager in charge of the prison) to let her know the situation.

49. The officer came back to the cell after five minutes with several colleagues. A colleague unlocked the cell and she went in and found the man hanging from the window by a ligature made from bedding. One of the officers radioed a code blue emergency, used to indicate a life-threatening medical emergency, such as when a person is found hanging, unconscious or not breathing. She cut the ligature from the window bars. She told us that the ligature was tight

around his neck, and that she had to loosen it before she could cut it free. Her colleague then started cardiopulmonary resuscitation. The control room log shows the code blue was called over the radio at 1.16pm and control room staff called an ambulance at 1.17pm.

50. Nurses arrived within 80 seconds of the code blue and continued with cardiopulmonary resuscitation, assisted by an officer. Paramedics arrived at 1.26pm and took over the man's care. The paramedics took him to hospital, where he was admitted him to the intensive care unit and placed on life support.

51. The man's family lived in the Birmingham area, and the prison asked West Midlands Police to contact his family that afternoon to inform them what had happened. A prison manager and a family liaison officer met the family at the hospital. The prison paid for their hotel accommodation and travel costs. In the following days, healthcare staff at Humber kept in contact with hospital staff who informed them that he was in a critical condition and the prognosis for his recovery was very poor.

52. On 25 November, a member of staff submitted an intelligence report. At the hospital, the family had told one of the escort officers that the man had previously told them that he was in debt to other prisoners and was under pressure to pay this back. They said that they had previously paid £200 into a bank account for him, and there had been other times when he had asked for money that they could not afford to pay. The family told us that they had been two occasions when they had put between £20 and £30 in envelopes and sent to an address given to them by him on one occasion and by another prisoner, who they did not know, the other time.

53. On 26 November, security staff and the police liaison officer at Humber searched the cells of two prisoners who the man had named when he was at hospital on 21 November. They did not find any evidence linking the prisoners to him.

54. A few days later, after an assessment by a consultant, doctors withdrew life support and the man died. The prison maintained contact with his family for ongoing support and offered a contribution towards funeral expenses, in line with national guidance.

Support for prisoners and staff

55. A manager debriefed the staff involved in the emergency response and offered them the support of the prison's care team.

56. Staff, including members of the chaplaincy team, supported prisoners affected by the man's death. Staff reviewed prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by his death.

ISSUES

Management of risk of suicide and self-harm

57. The man was on an ACCT when he arrived at Humber on 18 July. The sole issue on the caremap was to arrange for a transfer from Dovegate. As this action had been completed, it was appropriate to close the ACCT on 19 July. There was no reason to consider that he was at risk of suicide or self-harm at the time.

58. Between July and November, several members of staff reported that the man was low in mood. However, he had frequent contact with members of the mental health team, who did not consider that he was at risk of suicide or self-harm. Staff appropriately opened an ACCT on 21 November, after he said he had taken an overdose. A manager completed an immediate action plan within an hour and assessed him as at raised risk of suicide and self-harm. The level of observations was set at five an hour, which is the initial level set for any ACCT opened at Humber.

59. The first ACCT case review assessed that the man remained at raised risk of suicide or self-harm. A custodial manager and a nurse agreed to reduce the level of observations to three per hour. We are satisfied that this was a reasonable level of observations in the circumstances.

60. The ACCT review recognised that the man was fearful in his current location. Although, he had been allocated a different wing when he came back from hospital, he had refused to come out of his cell and said he was in fear of his safety. He was clearly very anxious to move and the review set a caremap action that he should move to the Everthorpe site. The custodial manager said that he had explained to him that this would not happen over the weekend but he would move on Monday. We have not seen any evidence that by the afternoon of Monday 24 November any firm arrangements had been made to transfer him to the Everthorpe site and staff were not able to give him any assurance that he would move that day. It is apparent this increased his level of anxiety. He had been promised that he would be moved to the Everthorpe site, the week before, but that move had not happened.

61. PSI 64/2011, which sets out the policy on ACCT procedures, says that actions must be ‘time bound’. Although the custodial manager had told the man that he would move on Monday, the caremap action said “at first opportunity”, which we do not consider was sufficiently precise. The custodial manager was on leave for the week after the ACCT case review, but said that he had told wing staff that “it needs to happen”. We consider there was a lack of clarity about exactly who was responsible for ensuring the move took place and when. The caremap action gave responsibility to the OCA, a prison department, but no specific person, either in the OCA or on the wing, was named as responsible for ensuring the move happened. The guidance in the PSI says that “the person(s) named against each of the ‘actions required’ in the caremap must complete their actions by the date given. Where this is not possible, they must inform the case manager who must note this and the new date for completing the action against the relevant entry in the caremap, as well as considering potential heightened risk this may cause”.

62. Both the ACCT assessment and the first case review assessed the man's level of risk as raised. To help reduce this risk they set one caremap action for him to move to the Everthorpe site. We consider that this was an appropriate action but we are not satisfied that the prison gave it enough priority to help reduce his risk. There was insufficient clarity about how and when the transfer would be arranged and who was responsible for ensuring it happened. We make the following recommendation:

The Governor should ensure that ACCT caremap actions, designed to reduce a prisoner's risk, are given appropriate priority, are time-bound and indicate the person or persons responsible.

Allegations of bullying and debt

63. While he was at Humber, the man said he had little support on his wing and alleged several times that other prisoners had threatened him. On 14 November, he told a nurse from the mental health team that he was taking drugs and getting into debt. He said that other prisoners were putting pressure on him to collect packages that had been thrown over the wall. The nurse reported this to the security department, who agreed that he should move to the Everthorpe site, but this did not happen. Eventually the OCA said that the move would take place on 20 November, but again this did not happen. The next day, he took an overdose.

64. On the morning of 21 November, the man told the nurse that the threats from other prisoners on the wing had got worse and he was worried about his safety. He took an overdose that afternoon because he had not been moved and said he felt unsafe. Later, at the hospital, he told an officer that two prisoners, who he named, had threatened him on the wing and had asked him to collect a parcel of drugs. However, there is no record of any of these allegations in his intelligence file, and no evidence that anyone investigated them at the time. It was not until 26 November, two days after he had hanged himself, that the cells of the two prisoners he had named were searched. Nothing was found to connect them with him.

65. While we have found no firm evidence of bullying, it is possible that the man was being threatened by other prisoners because of drug debts. His family told a prison family liaison officer that they had previously paid off debts and that he had asked them for more money. In his last telephone call home, he had asked his sister for money.

66. On 14 November, the man told a nurse that he felt unsafe and that other prisoners were pressuring him to collect contraband. The nurse appropriately reported this to the security department, who agreed he should be moved to the Everthorpe site. We are concerned that this transfer, which might have relieved his anxieties and prevented him taking an overdose on 21 November, did not happen and the staff did not appear to have considered whether his fears about his safety might made him at risk of suicide and self-harm. We are also concerned that there is no evidence of any investigation into his allegations at the time. We make the following recommendation:

The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged

perpetrators are appropriately challenged; and that victims are effectively supported and protected and the possible impact on their risk of suicide and self-harm is considered

Clinical Care

67. The clinical reviewer found that the care the man received at Humber was comparable to that he could have expected to receive in the community. He was satisfied that the man received appropriate support and advice from the primary mental health team. In his clinical review, he identified some healthcare matters, not related to the circumstances of his death, which the healthcare manager will need to address.

Emergency Response

68. After an officer found the man's observation panel covered by a towel, and he did not respond, she went to get help and inform the orderly officer. She did not radio for help as we would have expected and it was five minutes later before she came back with other officers and opened the cell.

69. Prison officers have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there appears to be immediate danger to life, staff can unlock and enter a cell on their own, without the authority of the orderly officer. However, staff are not expected to take action that they assess would put themselves or others in unnecessary danger.

70. The officer was unaware that the man had hanged himself and, although he was on an ACCT, could not have been sure that this was a life threatening situation. However, it is a concern that she did not know that there were any circumstances when opening a cell alone is permitted. Five minutes is too long a delay to open the cell of a prisoner, who is at risk of suicide and self-harm, when staff cannot see into the cell and cannot get a response from the prisoner.

71. Once the code blue was called, the control room called an ambulance immediately, officers started cardiopulmonary resuscitation quickly and healthcare staff were present within seconds. We are satisfied that the emergency response from this stage was handled well. However, when she found the man's observation panel covered and could get no response from him, if she did not consider it was safe to open the cell on her own, the officer should have radioed for urgent assistance and remained at the cell until help arrived. We cannot know whether the delay affected the outcome for him, but early intervention when a prisoner is found hanging can save their life. We make the following recommendation:

The Governor should ensure that all staff understand that they should summon help by the quickest means available where there is potentially a risk to life, and that, subject to a personal risk assessment, they should enter a cell alone.

RECOMMENDATIONS

1. The Governor should ensure that ACCT caremap actions, designed to reduce a prisoner's risk, are given appropriate priority, are time-bound and indicate the person or persons responsible.

2. The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that victims are effectively supported and protected and the possible impact on their risk of suicide and self-harm is considered

3. The Governor should ensure that all staff understand that they should summon help by the quickest means available where there is potentially a risk to life, and that, subject to a personal risk assessment, they should enter a cell alone.