A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Northumberland in September 2014

Our Vision

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

This is the investigation report into the death of a man, who was found hanged in his cell in HMP Northumberland in September 2014. He was 45 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer reviewed the clinical care that the man received at Northumberland. The prison cooperated fully with the investigation.

The man was remanded to HMP Durham in December 2013. He transferred to HMP Northumberland in May 2014, after he had been convicted and sentenced to eight years imprisonment. He had a number of risks and triggers for suicide and self-harm, including guilt about his offences, low self-esteem and apparent depression. However, he always maintained that he had no intention of harming himself.

On a morning in September, a prisoner, who had been unlocked early, went to the man's cell to say good morning. When he got there, he saw that the man was hanging from the window frame and alerted officers. The officers and a nurse checked the man and concluded that he had died and that it was too late to attempt to resuscitate him. This was an appropriate decision.

The investigation found that the man received good support from a small number of specialist staff who got to know him well, but there was little evidence of support from residential staff. The clinical reviewer found that healthcare staff did not use structured tools to assess and treat depression, but his designated mental health nurse and a prison GP reviewed him regularly. They recognised the man had a consistently low mood, but did not believe he needed to be managed under Prison Service suicide and self-harm prevention procedures and did not consider that he would take his life. Sadly, this assessment turned out to be incorrect, but I do not criticise the staff's judgement. He was a troubled man, but not everyone who has a low mood or is depressed is at risk of suicide or self-harm and I consider it would have been very difficult to predict or prevent this man's death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2015**

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SUMMARY

1. On 2 December 2013, the man was remanded to HMP Durham, charged with a number of counts of ill-treating and sexually assaulting patients at the care home where he worked. He had reported the offences himself. This was his first time in prison.

2. When he arrived at the prison, the man told a nurse that he felt low in mood and vulnerable due to the nature of his offences. The nurse began Prison Service suicide and self-harm prevention procedures (known as ACCT). The ACCT was closed three days later when he said that he had no thoughts of suicide or self-harm and staff concluded that he was not at risk.

3. In January 2014, the man was convicted of the offences. In April, he was sentenced to eight years imprisonment. Throughout his time in Durham, he was worried that other prisoners would attack him because of his offences. Officers tried to reassure him that he would be safe.

4. The man transferred to HMP Northumberland on 16 May and, after three weeks living in the induction unit, he moved to one of the vulnerable prisoners' wings. A reception officer had referred him to the mental health team when he first arrived and the same mental health nurse saw him each week after that.

5. The man was consistently low in mood but always maintained that he had no thoughts of harming himself. Staff who had contact with him did not consider that he needed to be monitored under ACCT procedures. He had a job in the prison tailoring workshop, which he said he found helpful as a distraction, and his mother and partner were supportive. He also had some friends on the wing.

6. On a morning in September, a night patrol officer said that all the prisoners on the wing were in bed, when he checked them at about 6.00am. At 7.40am, a prisoner alerted staff when he looked through the man's door observation panel to say good morning and saw him hanging from the cell window. Officers responded quickly. The officers and a nurse checked the man but found no signs of life and concluded that it was too late to attempt resuscitation.

7. The man was troubled and was consistently in a low mood but staff who assessed him did not consider he was at risk of suicide. We are satisfied that they appropriately considered his risk when reaching this judgement, even if ultimately it was wrong. Just before his death there was little to indicate that his risk had changed and we consider that it would have been difficult for staff at Northumberland to have foreseen and prevented the man's actions on that day. He received good consistent support from a mental health nurse but the clinical reviewer identified a need for some improvement in the assessment and management of prisoners with symptoms of depression. Although he received some good support from specialist staff, there was no evidence of active engagement with a personal officer or other officers on his residential unit. We have made two recommendations.

THE INVESTIGATION PROCESS

8. We issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and inviting them to contact the investigator if they had relevant information. Two prisoners responded.

9. The investigator obtained copies of the man's prison and healthcare records. He subsequently interviewed ten members of staff and five prisoners.

10. The investigator informed HM Coroner for Northumberland North District of the Ombudsman's investigation and we have sent him a copy of this report.

11. NHS England (North East Area) appointed a clinical reviewer to review the man's clinical care at HMP Northumberland.

12. One of the Ombudsman's family liaison officers contacted the man's partner to inform her of the investigation. The man's partner said that he had written to her to say he had lost weight, was not mixing with other prisoners and often thought that he would not be able to finish his sentence. She shared some of his letters with the investigator. She wanted to know whether the man had received appropriate mental health support at Northumberland.

13. The man's partner and father received a copy of the draft report. The family identified no factual inaccuracies and were satisfied with the report.

HMP NORTHUMBERLAND

14. HMP Northumberland was formed in 2011 by the merger of two separate prisons, HMP Acklington and HMYOI Castington. The prison is a medium security prison and holds up to 1,300 sentenced men. Since 1 December 2013, Sodexo Justice Services has managed the prison

HM Inspectorate of Prisons

15. The most recent inspection of HMP Northumberland was in September 2014. Inspectors found that the number of self-harm incidents was low, as was the number of ACCT documents opened. The quality of most ACCT documents was better than inspectors often saw at other prisons and prisoners were positive about the level of support they received. Inspectors found that Listeners (prisoners trained by the Samaritans to support other prisoners) were not widely promoted across the establishment and felt unsupported by prison staff.

Independent Monitoring Board

16. 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 its report for the year to December 2013, Northumberland's IMB stated: "Over the last two years the present management team has led the establishment through a series of complex transitions: the merger of two prisons, market testing, amalgamation of two sites, consolidation of facilities, and transfer of operations to the private sector. Maintaining continuity within an experienced management team has been an asset throughout this challenging period".

Previous deaths at HMP Northumberland

17. The man's death was the fifth apparent self-inflicted death at HMP Northumberland since September 2010. In two of the previous deaths, there were suggestions that the prisoners might have been bullied for medication or tobacco. The allegations were not substantiated in either case.

Assessment, care in custody and teamwork (ACCT)

18. ACCT - assessment, care in custody and teamwork - 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.

KEY EVENTS

19. On 1 December 2013, the man reported to the police that he had ill-treated and sexually assaulted patients at the care home where he had recently worked. He was held in police custody overnight and, on 2 December, was remanded to HMP Durham. This was his first time in prison.

20. A nurse assessed him in reception. The man said that he was feeling low in mood and vulnerable because of his offences. The nurse opened an ACCT and referred him to the doctor because of his reported alcohol consumption.

21. A doctor saw the man the same day. The man said that he had thought about suicide but did not have an active plan to kill himself. The doctor considered that the man's major concern was his fear of other prisoners. He had no symptoms of alcohol withdrawal at that stage, so he did not prescribe any medication. He referred him instead to the drug and alcohol team and to the mental health team.

22. At an ACCT assessment interview on 3 December, the man again said that he was feeling low but would never hurt himself. The first case review was held soon after. The review panel assessed him as low risk for self-harm and set the next review for 5 December. He said that he was worried about his safety due to his offences, so staff moved him to the vulnerable prisoners wing that afternoon.

23. On 4 December, a nurse assessed the man's mental health and noted that he was very anxious and still adjusting to being in prison. The nurse found no evidence of acute mental illness and discharged him from the care of the mental health team. Later that day, an officer noted that he continued to be frightened that other prisoners would kill him and he had spent some time reassuring him that he was safe.

24. At a review on 5 December, staff closed the man's ACCT. They noted that he had no thoughts of suicide or self-harm and they did not consider he was at risk.

25. On 15 January 2014, the man was convicted on several counts of ill treatment and sexual assault. The court deferred sentencing to a later date.

26. Although he had previously discharged the man, the nurse saw him again on 14 February. He noted that the man had not made any progress since their first meeting in December, and seemed worse. He said that he was expecting a significant sentence and believed he would be murdered when he moved to a new prison after sentencing. The nurse arranged to see him again in March.

27. On 10 March, a healthcare support worker saw the man on the nurse's behalf. He noted that the man was working as a cleaner, was spending time in the open air each day at exercise periods and appeared well motivated. He was still worried about moving to a new prison. The healthcare support worker told him that he would probably go to a vulnerable prisoners' unit.

28. On 25 April, the man was sentenced to eight years imprisonment. A nurse saw him on 1 May and noted that he was keen to start work to understand why he had committed his offences. She noted that he was still scared that he would be murdered when he moved to a new prison. He said that he would like to be prescribed antidepressants and the nurse advised him to make an appointment to see a doctor. On 12 May, he told his personal officer that he had expected his sentence.

29. On 13 May, the man saw a doctor and told him that he was not suicidal but would prefer to be dead rather than in prison. The doctor prescribed a 28-day course of sertraline, an antidepressant. He did not begin ACCT procedures.

HMP Northumberland

30. On 16 May, the man transferred to HMP Northumberland as a standard move from a local prison, after sentencing. An officer saw him for a routine induction interview when he arrived. She noted that he was struggling to come to terms with his sentence and arranged for peer supporters (Listeners and prisoner mentors) to speak to him. She referred him to the mental health team and noted that he was pleased about that.

31. On 19 May, a nurse saw the man for an initial mental health assessment. The nurse noted that he had long-standing difficulties with low mood and low self-esteem, as well as more recent difficulties linked to his offences. The man said that he was not feeling any benefits from the antidepressant he had been taking since 13 May. The nurse told him that it took time for the medicine to take effect, so he should continue taking it as prescribed. The nurse noted that he had said that he had no thoughts of self-harm and that his family and partner gave him reason to live. The nurse suggested that he should focus on adjusting to life at Northumberland and addressing his initial sentence plan targets, after which he would be able to engage better in therapeutic work.

32. On 3 June, the man met his offender supervisor. The offender supervisor told the investigator that his job was to be a link between prisoners and their offender managers (previously known as probation officers) in the community. He gave the man the contact details for his offender manager and spoke to him about his offences and the programmes he would need to do as part of his sentence plan. The offender supervisor told him that he should complete the Sex Offender Treatment Programme (SOTP). He said that the man was keen to participate and wanted to understand his motivation for offending. The offender supervisor later sent a letter to the man explaining that he had been added to the assessment list for SOTP and that he would probably be assessed within 12 months.

33. On 6 June, a doctor reviewed the man's medication. The man reported that he had still not noticed any benefits from his antidepressant medication. He said that he did not think his life was worth living, but he did not intend to harm himself. The doctor told the investigator that he was close to tears through most of the consultation, but she did not think that he needed to be monitored

under ACCT procedures. She doubled the dose of the antidepressant to 100 milligrams a day.

34. On 9 June, the man moved from the induction unit to Houseblock 12, one of the prison's houseblocks for vulnerable prisoners. That day, he started working full-time in the tailoring workshop. He told the workshop instructor that he was scared of being assaulted or even murdered. She said that she did not tolerate bullying and asked him if anyone had bullied him. He told her that no one had, but he still thought that he was at risk.

35. The workshop instructor said that she had similar conversations with the man for the next two days, when he was tearful and distressed. He told her that he felt he had nothing to live for. On 11 June, she phoned the mental health team who told her that a nurse was on the man's houseblock at the time. The workshop instructor therefore arranged for the man to go back to the wing for the nurse to see him. She told the investigator that she had received ACCT training, but thought that the wing staff and the nurse would be better placed to decide whether they needed to open an ACCT, once they had seen him.

36. The nurse and another mental health nurse saw the man on the wing. He told them that he was not sure if he would be able to cope with at least four years in prison, as well as life afterwards. The nurse advised him to persevere with the sertraline to allow the newly increased dose to take effect. He assessed the man's risk of suicide and self-harm as low and planned to see him again in a week. He did not think that the man needed to be managed under ACCT procedures. They agreed that the nurse would be the man's principal mental health nurse. The nurse told the investigator that he wanted to help the man adjust to being in prison and to explore issues that had troubled him in the past.

37. The workshop instructor told the investigator that, after 11 June, the man came to work most days and began to settle down. She thought that he was an intrinsically pessimistic man but she never considered that he needed monitoring under ACCT procedures.

38. The man saw the nurse again on 18 June, and again said that he was struggling to cope with his sentence. The nurse concluded that he had symptoms of low mood and anxiety, but they were not so severe as to stop him from engaging normally in prison life. He told the man that his partner had written to the prison, as she was concerned about his physical and mental health. She was worried that he had lost a lot of weight, was not mixing with other prisoners and that he had told her he had had thoughts about not reaching the end of his sentence. She said that he had always been a "troubled man" and asked that he should have a mental health assessment. The man said that his partner had told him she would be writing. He told the nurse that he was beginning to eat a little more. The nurse again assessed that his risk of suicide and self-harm was low. His protective factors included his prison job and the support he was receiving from the mental health team.

39. The nurse next saw the man again on 16 July. He said that his partner had recently visited him, and that she would be visiting again at the end of the

month, which he was looking forward to. He said that he still felt low in mood, but that he had felt like that for most of his life. He said that he felt better when he was at work. The nurse noted that the man had limited coping strategies.

40. On 25 July, a doctor saw the man to review his medication. She noted that he was tearful and, although he was working, said he did not mix with other prisoners during work breaks. She told the investigator that she thought that he was much the same that day as he had been when she last saw him in early June. She said that her practice with patients such as this man was to ask the question, “Is life worth living?” He said that life was often not worth living, but that he would not do anything about it. The doctor said that she never thought that the man would take his life. She increased his sertraline to the maximum daily dose of 150mg and planned to review him four weeks later.

41. A chaplain visited the man on 27 July, after someone had suggested he might appreciate talking to someone from the chaplaincy team. The chaplain told the investigator that the man talked about his offences and about having lost a job that he had enjoyed. He said that many of his acquaintances had ended all contact with him, but that his partner continued to visit and support him. The chaplain said the man was tearful when he spoke about his partner. At the end of the meeting, he told the man to contact him if he wanted another chat, but he did not hear from him again.

42. On 4 August, the tailoring workshop began working on a different type of garment, which made the man very stressed. He told the workshop instructor that he did not cope well with change. He said that he still could not get used to prison and did not know about his future. At the end of the shift, she told him to take a few days off to think about whether he wanted to continue working in the workshop. She telephoned his wing and told an officer about her conversation with him. She told the investigator that the man returned to work a few days later and appeared to have settled again.

43. On 8 August, the man saw the nurse again and spoke about his feelings of low self-worth. The nurse recorded that he displayed self-loathing and helplessness, but that he did not seem as hopeless as when they had first begun working together. He noted that the man had no thoughts of suicide or self-harm, but that this might change if he was unmanaged. He told the investigator that he meant that the man’s risk would increase if he stopped engaging with his mental health support. The nurse said that there was never a time when he thought that the man was anything other than low risk or that he needed to open an ACCT.

44. The man telephoned his partner on 10 August. She told him that she had booked a visit for 24 August. During the conversation he said, “Don’t worry about me too much, but you know what state I’m in … I can’t get out of it.”

45. On 14 August, a nurse found the man low in mood, but less anxious.

46. The man telephoned his mother on 16 August. He said that he wanted her to know how sorry he was and that he was full of sorrow. She told him that he did not need to apologise to her.

47. On 21 August, the man again told the nurse that he felt low in mood, hopeless and guilty. The nurse again noted that he would be at risk of harming himself, if left unmanaged.

48. On 22 August, the doctor reviewed the man again. She told the investigator that they had discussed his medication and whether it was helping. She said that the antidepressants were not doing him any harm, but her view was that medication would not necessarily improve his situation, as it would not remove his feelings of guilt. She noted that they had a long discussion about the concepts of guilt and forgiveness. After seeing him, the doctor spoke to the man's nurse and to the prison's senior mental health nurse because she was concerned that the man was not making any progress. They agreed that the mental health team would continue to support him. The doctor said that she did not consider that she needed to open an ACCT that day, or any other time she had seen him.

49. On 26 August, a drug and alcohol recovery team worker saw the man, at his request. The man talked about his past misuse of alcohol and cannabis but, within a few minutes, began to speak about his offences, his remorse for his victims and the impact on his family. He said that he was seeing the mental health team. The drug and alcohol recovery team worker gave the man a workbook and asked him to think about why he had used alcohol and cannabis. He planned to see the man again but noted in his summary of the meeting that he "found it impossible to consider recovery [from substance abuse] until he has got his head around his sentence and his offence."

50. That day, the man told the workshop instructor that his mother was in hospital. He thought she might have had a stroke and he blamed himself. The workshop instructor tried to reassure him and advised him to phone his family for more information. He was a little better the next day. When he came to work on 28 August, he said that wing staff had told him that his mental health appointment had been cancelled. The workshop instructor phoned the mental health team and arranged an appointment for the next day. That was the last time she saw the man. She said that she was shocked when she heard that he had been found hanged, as she had never thought he would do such a thing.

51. The man's mental health nurse saw the man in his cell on Friday 29 August. He told the investigator that he had not cancelled the man's appointment that week, but that their consultations were not always on the same day each week. He noted that the man was worried about his mother. He noted that it was the man's birthday that day and that his partner had visited the previous Sunday. These two events had caused him mixed emotions. However, the nurse said that he engaged well and seemed hopeful about how things were going. He said that he saw no signs that the man was planning to harm himself.

52. A prisoner who lived in the cell next to him told the investigator that, although the man was very quiet, they became friends and chatted during their free time. He said that the man often said that he could not spend four years in prison, but he never suggested that he would harm himself. They had spoken on the afternoon before the man's death and he thought that he had been in a good mood at the time.

53. Another of his friends told the investigator that although the man found it difficult to come to terms with prison life and his offences, he had never said he would harm himself. On 31 August, he helped the man use the wing computer to book a visit from his partner.

54. The man's partner shared with us four letters that he had sent her. None was dated, but from their contents, it is clear that three were written some time between 19 May at the earliest and 27 June at the latest. The fourth was probably written in August. He wrote about his poor emotional state and his feelings of shame. He said that he did mix much with other prisoners, but did not mention having any problems with anyone. In what was probably the last letter, he wrote that he had "seen mental health again but nothing helps".

55. The night patrol officer on the man's houseblock on a night in August told the investigator that his shift started at 8.45pm and, after receiving a handover from the day staff, he completed a roll check to establish that all prisoners were accounted for and in their cells. He could not remember what the man was doing when he checked him. He said that it was a quiet night. He began a morning roll check at 5.30am, and pressed a number of cell alarms along his route as an audit trail. The cell alarm print off shows that he began checking cells on the fourth landing (where the man lived) at 6.00am. He said that all of the prisoners on the fourth landing were in bed when he checked.

56. At 7.40am the next morning an officer unlocked the man's neighbour: his was one of the first cells to be unlocked because he started work early. The neighbour went to the man's cell to say good morning. When he looked through the observation panel in the door, he saw the man on his knees at the back of the cell with a cord running from his neck to the window frame. He ran to the end of the landing and called out to the officer that the man had hanged himself.

57. The officer said that he looked in the cell and saw the man facing the window, partly obscured by the curtain. He was not sure what had happened but he unlocked the cell and at the same time shouted for help. He said that he did not immediately radio a code blue medical emergency (which indicates circumstances such as when a prisoner is unconscious or not breathing) as he was uncertain of the situation at the time. He went into the cell, pulled away the curtain, and saw that he was hanging from a shoelace attached to the window frame.

58. The officer cut the lace and lowered the man to the floor. He checked his wrist for a pulse but found none and there was no movement in his chest. He said that he did not attempt to resuscitate the man, as it was clear from the condition of his body that he had died.

59. A further officer arrived and also checked the man for a pulse. She agreed that he was dead. She had tried to radio a code blue alarm when he had called for help but got no response from the control room, as there was a lot of early morning radio traffic. One of the other officers had therefore pressed the general alarm. More staff responded and one was able to radio a code blue alarm. At about 7.42am, the control room called an emergency ambulance.

60. A nurse was in the healthcare unit when she heard the code blue emergency call and went immediately to the wing with a healthcare assistant. When they reached the wing, she went to the man's cell while her colleague collected emergency equipment from the wing office. The nurse said that it took around three to four minutes to reach the man's cell. She examined him for signs of life and found none. She and her colleague attached the defibrillator, which found no shockable heart rhythm. She decided that the man was dead and it would not be appropriate to attempt resuscitation. Another nurse had arrived by then and she agreed with the decision not to try to resuscitate him.

61. Paramedics arrived at the man's cell at 8.05am. They examined him and found no signs of life. They did not attempt to resuscitate him and pronounced him dead.

Contact with the man's family

62. The man had named his partner as his next of kin. One of the prison's family liaison officers and a colleague went to see the man's partner. They arrived at her home at just after 11.00am, and broke the news and offered condolences. The prison contributed towards the cost of the man's funeral, in line with national Prison Service guidance.

Support for staff and prisoners

63. The prison held a debrief with the staff involved in the emergency response and informed them of the support available from the care team. Staff reviewed all prisoners being managed under ACCT procedures in case they had been affected by the man's death. Staff offered additional support to the man who occupied the next cell to him.

Post-mortem

64. The man's cause of death was given as hanging. The pathologist explained that in cases such as this man's, he would typically have lost consciousness within four to eighteen seconds and death would have followed a few minutes later.

Events after the man's death

65. On 4 September, a prisoner told a chaplain that another prisoner had been bullying him and thought he might also have been bullying this man. Another chaplain submitted a violence reduction information report about this.

66. A senior officer investigated the prisoner's allegations. He found that other prisoners had also complained about the same prisoner, but there had been insufficient evidence to substantiate the claims. He interviewed the alleged perpetrator, who denied the allegations. He told him that his behaviour would be monitored under the prison's anti-bullying procedures. The investigator also spoke to alleged perpetrator, who denied that he had bullied other prisoners.

67. The prisoner told the investigator that the man's wing was the worst in the prison for misuse of drugs, drug debts and bullying. He said that the bullies were not vulnerable because of the nature of their offences, but had been moved to a vulnerable prisoner unit for other reasons such as getting into debt with other prisoners. He said that the other prisoner had started bullying him from the moment he arrived on the wing and he had also tried to bully the man.

68. Another prisoner also spoke to the investigator about bullying problems on the wing. He said that a prisoner had tried to bully the man into giving him items he had bought from the prison shop.

69. The prisoner who lived in the cell next door to the man and who seems to have been his closest friend in prison, said that he never witnessed the man being bullied and he had never told him that he was bullied. Another friend of also said that, as far as he knew, the man was not being bullied.

ISSUES

Managing risk of suicide and self-harm

70. The man had been managed under ACCT procedures for three days when he first arrived at Durham in December 2013. That was the only time an ACCT was used to monitor his risk during his time in prison.

71. 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 says that any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Northumberland should have recognised him as at risk of suicide and self-harm and opened an ACCT.

72. The PSI lists a number of risk factors and potential triggers for suicide that applied to the man: low socio-economic status, contact with mental health in-reach, low self-esteem and the nature of the offences. He told a nurse that he felt guilty, worthless and ashamed of his offences, which are also factors linked to risk of self-harm. He said a number of times that his life was not worth living and that he did not think he could cope with his sentence or with his life afterwards. However, this outlook on life did not seem out of the ordinary for him. His partner described him as troubled, even before his prison sentence, and his workshop instructor considered him a generally pessimistic man. He constantly maintained that he had no thoughts of suicide or self-harm. A mental heath nurse and a GP reviewed him frequently and did not identify him as at raised risk of suicide.

73. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. The workshop instructor and a prison doctor told the investigator that they had never considered the man at risk of suicide or self-harm. His friends at Northumberland agreed that they had never thought he would harm himself. A nurse, who had weekly contact with the man, did not consider that he would be at risk of suicide and self-harm, unless he stopped receiving mental health support. His last consultation with the nurse was just two days before his death, when he considered he seemed more hopeful.

74. We consider that the decision whether or not to open an ACCT was finely balanced. It is likely that even if the man had been managed under ACCT procedures, his risk would not have been regarded as high and it is very unlikely that monitoring levels would have been sufficiently frequent to prevent his death. We are satisfied that in the days leading up to his death, there was nothing to indicate to staff that his risk had heightened or that he was at imminent risk of suicide. We do not consider that staff could reasonably have been expected to predict and prevent his death.

Clinical care

75. The clinical reviewer found no evidence that the doctor or the mental health team used standardised tools to assess the man's risk of suicide and self-harm or to assess him for depression or anxiety. He did not believe it was necessary to prescribe sertraline, which is normally prescribed for major depressive episodes. It seemed that the mental health team viewed the man's low mood as sub-clinical and a consequence of his offence, his sentence, and adjustment to prison life rather than clinical depression. He noted that National Institute of Health and Care Excellence (NICE) guidelines recommend that antidepressants should not be used routinely to treat sub-threshold depressive symptoms or mild depression. However, the clinical reviewer considered that the man's care and treatment was generally equivalent to common and acceptable treatment in the community.

76. The clinical reviewer noted that the man did not seem to have had access to psychological therapy to help him manage his low mood and anxiety, despite his acknowledged lack of coping skills and desire to address his problems. A cognitive behavioural therapy approach was not used, although it appears that this was planned as the nurse noted on 29 August that this would be part of his revised plan for the man's ongoing treatment. We make the following recommendation:

    The Head of Healthcare should ensure that staff use validated standard assessment tools to assess anxiety, depression and the risk of suicide and self-harm and that clinicians follow NICE guidance for prescribing antidepressants.

Personal officer scheme

77. The prison has a personal officer policy, which states that personal officers are expected to aim to know about the prisoners they are responsible for including knowing about their personal circumstances. Personal officers are required to have fortnightly interviews with the prisoners and to make entries in their prison records of their discussions. Although introduced before Sodexo took over the operation of HMP Northumberland, the prison has confirmed that it continues to operate the personal officer scheme.

78. The man's designated personal officer was re-deployed to different duties elsewhere in the prison. He appears to have had no contact with the man and made no entries in his records. There are no substantive entries from other officers to cover the personal officer responsibilities.

79. The man clearly engaged very well with his mental health nurse and received good, regular support from him. He also seems to have been able to speak about his difficulties with the workshop instructor. Even so, effective personal officer support would have given him additional opportunities on his residential unit to discuss any concerns. When a personal officer scheme works well, it allows staff to get to know a prisoner and to be able to spot any changes in their demeanour.

The Director should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes.

Emergency response

80. The prisoner who lived in the next cell to the man saw him hanging from the window frame when he went to say good morning and alerted an officer. The officer called for help but did not hesitate in going into the cell. Due to the amount of radio traffic at that time of the morning, there was a slight delay before one of the officers was able to contact with the control room to raise a code blue alarm. We consider that the delay was minimal.

81. The officer and a nurse, who also responded, agreed that the man was clearly dead and that they should not attempt resuscitation. Although the prison's local contingency plans for when a prisoner is found hanging, state that resuscitation should be attempted if the prisoner is not breathing, the staff did not do so. Based on the nurse's account, and her clinical judgement, it seems clear that attempting to resuscitate him would not have been appropriate. We are satisfied that the staff did the right thing.

Allegations of bullying

82. After the man's death, a prisoner reported that he thought that another prisoner had tried to bully the man. He repeated his allegation to the investigator. Another prisoner gave similar information. Two other prisoners who were friends with the man, said that he was not being bullied. There is no evidence that the man ever mentioned anything to his partner or to staff, including his nurse and the workshop instructor with whom he seemed to have developed trusting relationships. There are no other grounds to suggest that he was being bullied. We conclude that there is no substantive evidence that he was being bullied.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that staff use validated standard assessment tools to assess anxiety, depression and the risk of suicide and self-harm and that clinicians follow NICE guidance for prescribing antidepressants.

2. The Director should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes.