Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a prisoner at HMP Hull in February 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Hull in February 2015. He was 53 years old. I offer my condolences to his family and friends.

I am concerned about omissions in the way Hull implemented suicide and self-harm prevention procedures. I am also concerned at the lack of effective personal officer support to him and that staff did not follow up concerns about his mental health. While it did not lead to a delay in this case, I am disappointed that, once again, we found that staff at Hull did not follow the correct emergency response procedures.

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 **October 2015**

Contents

Summary

Events

1. On 30 July 2014, the man arrived at HMP Hull charged with murder and several counts of rape. He had tried to kill himself before his arrest, so reception staff began Prison Service suicide and self-harm prevention procedures, (known as ACCT). A nurse referred him for a mental health assessment that evening, but this never took place. The ACCT was closed on 18 August when he said that he was no longer having suicidal thoughts.

2. On 15 October, the man's solicitor wrote a letter to Hull to say that he thought that the man was at risk of suicide. Hull began ACCT procedures on 16 October, but staff closed the ACCT the next day when he said he had no intention of harming himself.

3. The man's trial started on 27 January 2015. On his way to court that day, he told a nurse in reception that he felt depressed and no one was helping him. The nurse referred him for a mental health assessment, but did not tell anyone else. On 5 February, the jury retired to consider their verdict. The jury had not reached a decision by the end of the afternoon and he returned to Hull.

4. At 5.50am, the man's cellmate told the night patrol officer that the man was hanging out of sight of the observation panel. When officers went into the cell they attempted resuscitation. Paramedics arrived and, at 6.16am, pronounced him dead.

Findings

5. We found that ACCT procedures at Hull were not always completed correctly. One ACCT was closed at the first review without healthcare input or a caremap. The review panel also believed the man when he said he had never harmed himself, even though it was clearly recorded that he had tried to kill himself before his arrest.

6. There is little evidence that the man had meaningful interaction with staff, or that staff supported him as his trial approached. We were also concerned that he was referred for a mental health assessment on 30 July and 27 January, but he was never seen by the mental health team. (There were two other occasions when he was apparently referred to the mental health team but there is no record of these referrals and he was not seen by them.)

7. Although it would not have affected the outcome for the man, there was an unacceptable delay in calling an ambulance, a matter we have commented on before at the prison.

Recommendations

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

- Multidisciplinary case reviews are held with all relevant people involved in a prisoner's care;
- All known risk factors are considered, including historical information, when determining the level of risk of self-harm;
- Significant conversations with prisoners and their families are recorded in a prisoner's records;
- Caremap objectives are set to address the underlying causes of a prisoner's distress;
- Trigger points are considered in ACCT reviews and the triggers section of the ACCT document is completed.

- The Governor and Head of Healthcare should ensure that the mental health referral system results in the timely assessment and treatment of prisoners with possible mental health needs.

- The Governor 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.

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an ambulance without delay.

- The Governor should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and inviting anyone with relevant information to contact him. Two prisoners responded.

9. The investigator visited Hull on 11 February. He obtained copies of relevant extracts from the man's prison and medical records.

10. The investigator interviewed 11 members of staff and five prisoners at Hull on 11 February, 19 and 20 March 2015.

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

12. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation who sent the results of the post-mortem examination. We have given the Coroner a copy of this report

13. One of the Ombudsman's family liaison officers contacted the man's niece to inform her of the investigation and to ask if she had any issues that she wanted the investigation to consider. She wanted to know why her uncle was not on suicide watch and why he had not had a mental health assessment. She also wanted to know about marks on her uncle's face, which she saw when she viewed his body. She received a copy of the draft report and did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Hull

14. HMP Hull is a local prison, which holds approximately 1,000 unconvicted and sentenced men in ten residential wings.

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons (HMIP) last inspected Hull in October 2014. Inspectors found that initial ACCT assessments and records of observations and conversations were good, but too many ACCTs were closed prematurely. Inspectors found that the personal officer scheme was not functioning properly. They found that entries in case history notes were made regularly, but were often perfunctory and did not demonstrate that officers knew the prisoner well. Inspectors found that the mental health teams had good relationships with other healthcare staff and officers. The in-reach team received five new referrals a week and routine cases waited five days to be seen. A range of interventions was available and patients had good access to a psychiatrist who attended the prison each week.

Previous deaths at HMP Hull

16. There have been eight deaths at Hull since May 2011, including the man. Three of these were the result of hanging, four were from natural causes and one was unexplained.

17. In both of the deaths from hanging, we found failures in the ACCT process: in one case ACCT reviews were held without healthcare representatives and in the other case there were deficiencies with completion of the caremap. Similar issues arose in this investigation.

18. In three deaths between May 2011 and January 2015, we found there were delays in calling an ambulance, which was also an issue in this investigation. In one of those cases, we made no recommendation as Hull told us that they had changed their practice to ensure an ambulance would be called without delay.

Assessment, Care in Custody and Teamwork (ACCT)

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

Key Events

20. On 25 July 2014, the man was arrested on suspicion of the murder of a stranger and on several counts of the rape of an ex-partner. He remained in police custody until 30 July when he was remanded to HMP Hull. This was not his first time in prison.

21. The man arrived at Hull with a suicide and self-harm warning form. The police officer who completed the form noted that he had self-harmed in the last six months, but did not include any more information. The police officer recorded that apparently he said he would take his own life at some time before his arrest, but had then said he would not do so while in custody.

22. The officer working in reception said that the man had been on the local news so when he arrived staff knew who he was. The officer said that the man was very subdued; he answered the questions he was asked but did not elaborate. He told the officer that he had taken an overdose three days earlier. The officer opened an ACCT, noting that he had arrived with a suicide and self-harm warning form.

23. A nurse saw the man soon after for his initial health screen. She noted that he had taken an overdose while on the run from the police, but that he had no present thoughts of suicide or self-harm. She said that because he was a high profile prisoner he was admitted to the healthcare unit for his first few days, where staff would see him again to assess his mental health needs. She did not make a mental health referral.

24. The man told a nurse that evening that he was feeling depressed. She increased his ACCT checks from one to two an hour and sent a referral to the mental health team.

25. On 31 July, an officer assessed the man as part of the ACCT process. He said that he had no reason to live and would rather be dead than in prison. A Supervising Officer (SO) chaired an ACCT review shortly afterwards. The man attended, along with two officers and a nurse. He said that he was thinking about ending his life. The panel assessed his risk as raised (on a scale of low, raised or high). They kept his observations at two an hour and moved him to a cell with a camera to aid observation. The SO listed three actions on the caremap, including that staff should observe and support him, and the mental health team should see him. No one referred him to the mental health team.

26. A SO chaired the next ACCT review on 7 August. A second supervising officer, a nurse and the man also attended. The SO noted that he appeared settled, that he had no intention of harming himself and was ready to leave the healthcare unit. The panel assessed his risk as low but made no change to his level of observations. He moved to I Wing that afternoon (I Wing is the vulnerable prisoners' wing).

27. A SO chaired an ACCT review on 11 August. A second supervising officer, a nurse and the man were also present. He said that he still had thoughts of

suicide but he would not act on these thoughts. The panel again assessed his risk as low. The SO noted on the caremap that he had been referred to the mental health team that day. (The prison could not provide us with a copy of the mental health referral.)

28. A SO chaired an ACCT review on 18 August. The man and a nurse were also at the review. The SO noted that he was settled and quite upbeat and the nurse made a similar entry in his clinical record. He said that he was no longer having thoughts of suicide or self-harm and would speak to staff if anything changed. The review panel closed his ACCT.

29. The man's personal officer told the investigator that his main job was arranging staff leave and staff rotas, and he did not have daily contact with prisoners. He first met the man on 5 October. He told him he was his personal officer and said that even though he did not work on I Wing, the man would just have to ask an officer to call him to the wing if he needed anything.

30. The man's solicitor wrote a letter to the prison on 15 October to say that he was concerned about his depressed state at a recent meeting with him and he thought he might be at risk of suicide. A SO opened an ACCT and spoke to him. He said he was feeling low due to being in prison but said that if he wanted to take his life, he would have done it already. He added that he was surprised at the extent of his solicitor's concern. The SO did not enter any potential significant approaching events in the triggers section of the ACCT, (an example of a trigger is the start of trial).

31. An officer assessed the man for the ACCT on 17 October. He said that he was not sleeping well but he had never self-harmed in the past and had no thoughts of self-harm. The officer noted that he was to be referred to the mental health in-reach team. There is no record that he was referred to the mental health team.

32. A SO chaired the ACCT case review later that morning. The man attended the review, as did a prison chaplain. There was no nurse at the review, and the SO did not speak to anyone in the healthcare team. The man repeated what he had told the officer about having no past or present thoughts of suicide or self-harm. He said his solicitor just wanted to speed up a referral to a prison doctor. The SO did not complete a caremap, but he wrote in his summary of the review that the man should apply to see a doctor. The SO closed the ACCT, noting that all at the review agreed to this.

33. The man's personal officer saw him again on 18 October for a personal officer review. The man said that he had no issues apart from the fact that he was waiting for a £200 cheque to be cleared.

34. A SO saw the man on 24 October for a post-closure ACCT review. The SO recorded that the man had no unresolved concerns, even though he had not seen a doctor by this time.

35. The man appeared at court for a remand hearing on 31 October and 7 November. On both occasions, a nurse in reception assessed him as fit to go to court, and recorded that he had no health issues.

36. The man's personal officer did not meet him again until 29 November. He noted that as a remand prisoner, he chose not to work or attend education. On 13 December, he noted that the man was in a positive mood.

37. The man spoke to his niece every few days. She telephoned Hull's control room on the afternoon of 15 December and told an officer that she was concerned that he was at risk of suicide. The officer contacted a SO on I Wing to pass on the message. The SO said that he spoke to the man, who was surprised that his niece had telephoned the prison as he did not think he had said anything for her to be concerned about. The SO said the man was in a reasonably good mood and assured him that everything was fine. He said that he would have opened an ACCT if he had had any concern. The SO did not make a record of his conversation with the man, and he accepted he should have done.

38. When the man spoke to his niece on 20 December, he told her not to telephone the prison again because he was already on a suicide watch.

39. The man's personal officer last saw him on 24 January, six weeks since their previous meeting. The man said his trial was starting the following week, and he and his solicitor were prepared. The officer did not think the man was at risk of suicide or self-harm.

40. The trial started on 27 January. A nurse saw the man he went to court. He said that he was depressed and no one was helping him. She told the investigator that he said he had no thoughts of suicide or self-harm, but she did not record this. She said that she asked him if he had a mental health keyworker. He said he did not, so she decided to refer him to the mental health team. She used a self-referral form, although she completed it on his behalf. She left most of the referral form blank, including whether he had thoughts of harming himself or ending his life. She indicated that he felt down, depressed or hopeless nearly every day, and that he had told her no one was supporting him.

41. On 28 and 29 January, reception nurses found the man fit enough to go to court. He said on both days that he had no health concerns and had no thoughts of suicide or self-harm. A nurse saw him about a possible chest infection when he returned from court on the afternoon of 29 January. A prison GP prescribed antibiotics. He was fit to return to court the next day, Friday 30 January. His trial resumed on Monday, 2 February and nurses assessed that he was fit enough to go court that morning and the next two mornings.

42. The man telephoned his niece for the last time on 4 February. He sounded annoyed about how his trial had gone that day.

43. A nurse saw the man before he went to court on the morning of 5 February. He told her that he was fit and well and had no thoughts of suicide or self-harm.

44. A prisoner said that his trial started at around the same time as the man's trial, so they spent time together in the court holding room. He told the prisoner that he should be convicted of manslaughter. When the judge directed the jury on 5 February, he told them that they could only consider whether he was guilty of murder. The prisoner said that the man was annoyed with the judge's directions. They spent around two hours together in the court holding room until both of their trials were adjourned for the day and they returned to Hull. (The man did not see a nurse when he returned from court that afternoon. Nurses only see prisoners on return from court if there has been a change of circumstance or if a concern has been raised during the day.)

45. An officer said that he saw the man in reception several times during his trial. He was always quiet but there had been no time when he thought he needed to open another ACCT. The officer was working in reception on 5 February and spoke to him when he went to court in the morning and when he came back in the evening. The officer said that the man was in good spirits when he came back and he smiled, which the officer had not seen before.

46. An officer walked the man from reception back to his wing, along with the other prisoner. He overheard the prisoner ask the man what he was going to watch on television that night and he said he was tired and would probably go to bed early. The prisoner remembered the man said he would see him tomorrow and he asked him to bring matches.

47. The investigator spoke to three of the man's friends on I Wing. All three said he became chattier when his trial started and seemed to enjoy briefing them on how the trial was proceeding. None of them thought that he was going to harm himself.

48. The man's cellmate said that the man was annoyed when he came back from court on 5 February, because he thought the judge had directed the jury to return a guilty verdict. They spent the evening watching television and the man went to sleep at about 11.00pm.

49. The night patrol officer on the man's wing that night carried out a roll check at about 8.00pm. He had no reason to check the man's cell again through the night. He carried out another roll check at about 4.45am, and the man was in bed. He went back to the cell at 5.50am to tell him that it was time to get ready for court. When he looked through the observation panel, he was not in his bed. He called his name but got no response, so he knocked on the door. The cellmate was in the top bunk and he sat up. When he asked him if he could see the man, the cellmate gestured to suggest that he might be hanging in the toilet area. He radioed a code blue alarm.

50. The night patrol officer said that he could not see the man, so he needed back-up before he could go into the cell. An officer responded to the code blue alarm and reached the cell within two minutes. The night patrol officer unlocked the door, cut the bed sheet from around the man's neck, and lowered his body to the floor. He said that he was an experienced first aid instructor and he started chest

compressions. He said there was not enough room in the cell for the officer to help so he continued giving compressions alone until a nurse arrived.

51. A nurse was in the healthcare unit when he heard the code blue alarm. Nurses at Hull do not carry keys at night, so he was taken to I Wing by an officer and reached the cell at about 5.54am. He said that there were no immediate signs that the man was alive: his pupils were fixed, and he was not breathing. He started emergency breaths and continued chest compressions until paramedics arrived.

52. The officer working in the control room did not call an emergency ambulance when the code blue alarm was first raised, but called one at around 5.55am, when the prison's night manager confirmed that one was needed.

53. Paramedics reached the prison at 6.05am and arrived at the cell at 6.10am. The nurse left the cell to allow them to go in. They checked the man for signs of life and checked him with a defibrillator. The paramedics pronounced him dead at 6.16am.

54. The man left a letter addressed to the husband of the woman he killed. He said that it had been an accident and concluded by saying that he could not live with himself for what he had done.

Contact with the man's family

55. The prison contacted HMP Wakefield to ask for staff from that prison to break the news to the man's niece in person, which they did at around 9.00am. A prison manager visited her that afternoon and also met the man's mother and one of his brothers. Hull contributed towards the cost of the funeral in line with national Prison Service guidance.

Support for staff and prisoners

56. A prison manager 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. The man's cellmate was moved to Hull's wellbeing unit for additional support.

Post-mortem report

57. The man's cause of death was given as hanging. The pathologist noted that he had three bruises to his face which he explained were minor injuries, consistent with minimal blunt force trauma, and were most likely to have occurred while he was hanging. The pathologist added that there was nothing to suggest that the injuries were caused through restraint or had been deliberately inflicted.

Findings

Management of risk

58. Reception staff appropriately identified the man as at risk of suicide or self-harm when he first arrived at Hull. He was monitored for nearly a month before staff agreed that he was no longer at risk and the ACCT was closed.

59. In October, the man's solicitor wrote to the prison because he was concerned that the man was at risk of suicide. A SO started ACCT monitoring on 16 October, but another SO closed the ACCT the next morning. The SO noted that the man said that he had never harmed himself and had no intention of doing so. He also noted that the man wanted to see a prison doctor, and had said his solicitor had just wanted to expedite this. He advised him to make an appointment with a doctor and he closed the ACCT.

60. We have a number of concerns about the way officers managed the ACCT on that occasion. Prison Service Instruction (PSI) 64/2011, which governs ACCT procedures, makes it clear that the first case review should include the ACCT assessor if possible, and a healthcare representative must contribute to the review. Neither the assessor nor a healthcare representative contributed to the man's case review. A SO closed the ACCT before completing a caremap, which could have highlighted that the man wanted to see a doctor. (He did not see a doctor after the review.) The SO did not write anything in the triggers section of the ACCT, yet the man was due in court later that month, and his trial was approaching. The SO accepted the man's word that he had never harmed himself, but his attempted suicide before his arrest was recorded in a previous ACCT and in his clinical record. The SO would not have had access to the man's clinical records, but this highlights the importance of healthcare staff's contribution to the ACCT process.

61. On 15 December 2014, the man's niece telephoned the prison to say that she was concerned that her uncle might be at risk of suicide or self-harm. A SO spoke to him, who said that everything was fine. The SO thought that he seemed in a reasonably good mood and decided that no further action was needed. The SO did not make a record of his conversation with him.

62. PSI 64/2011 requires that all staff who receive information, including from concerned family members, should consider opening an ACCT and record the information. The SO told the investigator he considered the man's risk of suicide or self-harm, but he did not record the conversation or the information received from his niece, as he was required to do.

63. PSI 64/2011 also lists a number of triggers that may increase a prisoner's risk of suicide or self-harm, including court appearances, especially the start of a trial or sentencing. On 27 January, the man told a nurse that he was depressed and no one was helping him. The nurse referred him to the mental health team, even though it would not have been possible to assess his mental health during his trial, because he would not have been in the prison.

64. The man would have been one of a number of prisoners passing through reception on their way to court that morning so his conversation with the nurse would have been brief. We believe the nurse should have identified him as at heightened risk that morning, and arranged for his risk to be assessed when he got back later that day. He would have had very limited contact with officers during his trial and we consider that the nurse should have opened an ACCT to offer him support.

65. We make the following recommendation:

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

- **Multidisciplinary case reviews are held with all relevant people involved in a prisoner's care;**
- **All known risk factors are considered, including historical information, when determining the level of risk of self-harm;**
- **Significant conversations with prisoners and their families are recorded in a prisoner's records;**
- **Caremap objectives are set to address the underlying causes of a prisoner's distress;**
- **Trigger points are considered in ACCT reviews and the triggers section of the ACCT document is completed.**

Mental healthcare

66. The clinical reviewer noted that the man was referred appropriately to the mental health team but he was never seen. The first referral seems to have been on 30 July 2014 when he first arrived at Hull. Further referrals were noted as being made on 11 August and 17 October. The prison has not been able to provide copies of the mental health referrals from these three occasions.

67. A fourth referral was made on 27 January 2015 at the start of the man's trial. The final referral did not indicate a need for an urgent review and it had not been actioned by the time of his death. The clinical reviewer has pointed out that in the absence of a full and thorough psychiatric assessment, he did not have an individual care plan to minimise his risk. She has recommended that there should be an investigation to find out why he was not seen by the mental health team. She has made some additional recommendations in her clinical review about capturing key information which the Head of Healthcare will need to address. We support her recommendations, and add the following recommendation of our own:

The Governor and Head of Healthcare should ensure that the mental health referral system results in the timely assessment and treatment of prisoners with possible mental health needs.

Personal officer scheme

68. According to Hull's personal officer scheme, personal officers were expected to develop a positive professional relationship with the prisoners they were responsible for, including identifying any problems or concerns the prisoner may have. Personal officers were expected to make regular entries in the prisoner's records.

69. The man's personal officer said that he tried to see prisoners every fortnight, but he did not work on I Wing and there were two occasions when there was a six week gap between entries in the man's records. He said a reserve personal officer should have seen him in these periods.

70. When the personal scheme works well, it is an opportunity for staff to get to know a prisoner and to be able to spot any changes in their demeanour. It is not satisfactory that personal officers for prisoners on I and J Wings are not based on those wings. We make the following recommendation:

    The Governor 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

71. We are concerned that there was a five minute delay before the control room called an ambulance. The officer who was working in the control room told the investigator that he had to wait for the night manager to confirm the nature of the emergency before deciding whether an ambulance was needed.

72. Prison Service Instruction 3/2013 (issued February 2013) requires that governors must have a medical emergency response code protocol to ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. Hull's current protocol was dated 2013, but makes clear that any member of staff can ask for an emergency ambulance. It is unacceptable that there are still delays at Hull in calling emergency ambulances. We make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an ambulance without delay.

73. We are also concerned that a nurse had to wait for an officer to collect him from the healthcare unit, as he did not have keys to move through the prison at night. This meant that he did not arrive at the man's cell until four minutes after the night patrol officer found him. We have previously made recommendations to other prisons where nurses had to wait to be collected, and they have amended their security policy to make sure that nurses have easier access to the rest of the prison at night.

74. We consider the prison should do everything it can to ensure that the preservation of life is placed over security concerns. The current arrangements mean there is an inherent and unacceptable delay in healthcare staff reaching a prisoner in an emergency at night. We make the following recommendation:

The Governor should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.