Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mathew Sims a prisoner at HMP Nottingham on 15 August 2016

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

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

Mr Mathew Sims died in hospital on 15 August 2016 after he was found hanged in his cell on 6 August at HMP Nottingham. Mr Sims was 32 years old. I offer my condolences to Mr Sims' family and friends.

I am concerned that staff at Humber and Nottingham prisons missed opportunities to identify Mr Sims' risk of suicide and self-harm, to address his fears for his safety and his potential mental health needs and to share important information about him and give him the support he needed.

I am disappointed that I must repeat previous recommendations to Nottingham about emergency codes and the need to record information about risk.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. On 1 March 2016, Mr Mathew Sims was remanded to HMP Lincoln, charged with aggravated burglary and violence against his partner. At his initial health screen, he told a nurse that he might harm himself. He had depression and flashbacks about his brother, who had taken his life in prison in 2005. He was discharged from the mental health team's caseload after he missed two appointments and declined their support. Mr Sims was later sentenced to three and a half years in prison. Intelligence indicated that Mr Sims was involved in the drug and gang culture at Lincoln and used New Psychoactive Substances (NPS).

2. On 1 June, Mr Sims was transferred to HMP Humber. On 10 June, he was found with a ligature around his neck and staff started suicide and self-harm prevention measures (known as ACCT). Mr Sims was worried about his safety, grieving for his brother and having relationship issues. Staff assessed his risk as low, stopped ACCT monitoring two days later and completed a post-closure review on 19 June.

3. On 21 June, Mr Sims was transferred to Nottingham for a court appearance. He did not want to go because he was frightened that he would be assaulted by gang members there. Mr Sims' person escort record (which accompanies prisoners between prisons and the court) did not note that he had recently tried to take his life or that he had been supported by ACCT procedures.

4. On 22 June, Mr Sims attended court but became abusive to staff and flooded his cell because he did not want to return to Nottingham. His person escort record noted that he should not return to Nottingham. The court adjourned Mr Sims' hearing because of his behaviour and a prison manager at Nottingham authorised his return to Nottingham. Mr Sims was taken to the segregation unit but was moved the same day after a nurse assessed that he was not fit to be segregated. He was not referred to the mental health team.

5. A nurse at Humber left a voicemail for Nottingham's mental health team to let them know that Mr Sims needed a mental health assessment. It is not clear why this never happened during Mr Sims' four months at Humber.

6. On 4 August, staff found Mr Sims with a mobile phone and charger in his cell. They removed them, having placed Mr Sims under restraint. And, on 6 August, Mr Sims attended a disciplinary hearing, which was subsequently adjourned. At around 5.25pm, an officer allowed Mr Sims to phone his partner as they had relationship difficulties. Nottingham has no record of this call and we do not know what Mr Sims or his partner said.

7. At 7.48pm, an officer found Mr Sims hanged in his cell, radioed for medical assistance, cut the ligature and staff tried to resuscitate him. Staff radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has difficulty breathing) four minutes later and an ambulance was called promptly. Paramedics obtained a pulse for Mr Sims and took him to hospital, where he died on 15 August. His family were with him when he died. A toxicology report for Mr Sims detected NPS in his bloodstream.

Findings

8. Humber did not adequately support Mr Sims. They did not identify or address his risk factors or level of risk appropriately. The ACCT case reviews were not multi-disciplinary, the caremap actions did not cover all Mr Sims' risk factors and were for him to complete. Staff stopped ACCT monitoring prematurely while his risk factors remained.

9. Humber should have assessed Mr Sims' mental health after he tried to take his life. Nottingham also missed opportunities to refer Mr Sims to their mental health team, particularly at reception and when he was assessed as unfit to be segregated.

10. Humber did not highlight to Nottingham information about Mr Sims' recent attempted suicide, that he had been subject to ACCT monitoring, that he had been involved with gangs and used NPS at Lincoln or information about his potential mental health issues. We recognise that a nurse left a voicemail for Nottingham's mental health team but no one received the message.

11. Staff at Nottingham should have considered all available information in Mr Sims' prison record and intelligence file. They underestimated Mr Sims' risk of suicide and self-harm at reception despite his clear fears for his safety, which underlay his poor behaviour as he did not want to go to Nottingham. Mr Sims' risk was not reviewed when he returned from court, and no plan was put in place to address his safety at Nottingham.

12. Nottingham failed to build a picture of Mr Sims' risk of bullying and suicide. Mr Sims told staff that he had fears for his safety and named alleged perpetrators, He also behaved poorly in an attempt not to move to Nottingham and then not to return there after his court appearance. Had staff investigated his concerns from the outset, the outcome might have been different for Mr Sims.

13. The officer who found Mr Sims hanged should have radioed an emergency code blue. There was a delay of four minutes before a code blue was radioed and an ambulance was called.

Recommendations

HMP Humber

- The Governor and Head of Healthcare of Humber should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance. In particular:
    - There should be a multi-disciplinary approach for all case reviews, with healthcare staff attending all first case reviews.
    - ACCT caremaps should have specific, meaningful and time bound actions, aimed at reducing prisoners' risks to themselves, progress should be considered at each review and the caremaps updated if additional needs are identified. Staff should not close ACCT plans until all caremap actions have been completed.

- ACCT reviews should consider and record all available information and known risks factors when determining the level of risk of suicide and self-harm.
- ACCT reviews should fully consider and record the impact of bullying or intimidation on the risk of suicide and initiate appropriate action.
- The level of a prisoner's risk should be assessed as t least raised after an incident of attempted suicide or self-harm.

- When transferring prisoners, the Governor and Head of Healthcare at Humber should ensure that staff share all relevant information about risk, including a mental health needs, with the receiving prison and complete person escort records fully and accurately.

HMP Nottingham

- The Head of Healthcare should ensure that staff refer prisoners to the mental health team where they have concerns about their mental health.

- The Governor and Head of Healthcare should ensure that staff, including reception staff, consider, record and address all the known risk factors of a newly arrived prisoner when determining his risk of suicide and self-harm and start suicide and self-harm prevention procedures if necessary.

- The Governor should ensure that that prison staff use the appropriate emergency medical code in a life threatening situation, and that control room staff request an ambulance immediately.

- The Governors of HMP Humber and HMP Nottingham should ensure that there is a co-ordinated approach to identifying indicators and risks of bullying and violent behaviour, including the impact of substances such as NPS. All allegations of violence, bullying or intimidation should be taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator visited Nottingham on 11 August 2016. She obtained copies of relevant extracts from Mr Sims' prison and medical records.

16. The investigator interviewed staff and two prisoners at Nottingham in September.

17. NHS England commissioned a clinical reviewer to review Mr Sims' clinical care at the prison. She conducted the clinical interviews with the investigator.

18. We informed HM Coroner for Nottingham of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Sims' sister and father to explain the investigation. Mr Sims' sister told us that Mr Sims was using 'Mamba', a new psychoactive substance (NPS), while he was in prison. She told him to ask for help but he was frightened that he would get into trouble if he told staff about it. She said that her other brother had killed himself in prison, which heightened Mr Sims' grief.

20. Mr Sims' family received a copy of the initial report. They did not make any comments.

Background Information

HMP Humber

21. HMP Humber is a resettlement prison in Yorkshire that holds up to 1,026 men. It was formed in 2014 by merging HMP Wolds and HMP Everthorpe. City Health Care Partnership provides healthcare services.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Humber was published in November 2015. Inspectors noted the increased availability and use of illegal drugs. They noted that Humber was not sufficiently safe and many procedures designed to underpin prisoners' safety were underdeveloped. They noted that it was common for prisoners to behave poorly but levels of self-harm were not high and prisoners reported positive relationships with staff.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for 2015, the IMB reported that they were impressed by Humber's efforts to counter the use of NPS.

HMP Nottingham

24. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holds up to 1,060 men. The segregation unit holds up to 12 men. Nottinghamshire Healthcare Trust provides health services at the prison.

HM Inspectorate of Prisons

25. HM Inspectorate of Prisons last inspected Nottingham in February 2016. At their previous inspection in 2014, they had serious concerns about many outcomes for prisoners and although they saw evidence that staff and managers were working hard to address areas of concern, inspectors found that Nottingham still faced many significant challenges. They said that there was too much serious violence and disorder. They said that NPS, in particular mamba, had become a major problem and many prisoners told inspectors that they felt unsafe.

Independent Monitoring Board

26. In its most recent annual report for the year to February 2016, the IMB reported that Nottingham's regime had often been restricted because of a lack of staff (though more officers had been recruited towards the end of year). The IMB were concerned about the level of assaults on prisoners and staff and the use of NPS, which increased violent behaviour, debt and bullying. The IMB commended the work of officers in the segregation unit but said the unit was not always staffed with selected and trained officers which made it difficult to identify and manage risks or engage positively with prisoners. They were concerned by the number of prisoners with mental health problems and the lack of suitable accommodation for them. The IMB welcomed Nottingham's efforts to detect illegal mobile phones.

Previous deaths at HMP Nottingham

27. Mr Sims was the second prisoner to take his life at Nottingham since January 2016. Our investigation of the other prisoner's death identified concerns about the use of NPS and poor risk assessment, both concerns we repeat in this report. There have been two further self-inflicted deaths since Mr Sims died which we are currently investigating.

Assessment, Care in Custody and Teamwork

28. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

NPS

29. New psychoactive substances (NPS), previously known as 'legal highs' (although they are now illegal), are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for NPS precipitating or exacerbating the deterioration of mental health with links to suicide and self-harm.

30. In July 2015, we published a Learning Lesson Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

31. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

HMP Lincoln

32. On 1 March 2016, Mr Mathew Sims was remanded to HMP Lincoln for aggravated burglary and violent offences against his partner. He had served time in prison some years earlier.

33. During his reception health screen, Mr Sims told a nurse that his brother had taken his life in prison in 2005. He said that he had depression and flashbacks to his brother's death, which were worse in prison, and he might harm himself at some point. Despite this, he denied current thoughts of suicide or self-harm or any drug misuse. She referred him to the mental health team.

34. Mr Sims declined to attend two mental health appointments on 24 and 29 March. A mental health nurse checked with Mr Sims that he did not want to see them. He again declined their support, and was discharged from the mental health team's caseload.

35. On 8 April, Mr Sims was sentenced to three and a half years in prison.

36. On 10 May, Mr Sims' partner was removed from his telephone and visitor list at her request. Mr Sims' sister told the investigator that Mr Sims' relationship with his partner was troubled.

37. That day, Mr Sims was involved in an altercation with another prisoner. Staff started violence reduction procedures and reduced his Incentives and Earned Privileges (IEP) level to basic. Mr Sims returned to standard IEP level on 25 May.

38. Staff at Lincoln completed a number of intelligence reports which indicated that Mr Sims used NPS, was involved in the prison's drug and gang culture, was bullying prisoners who were in debt for drugs and was using a mobile phone.

HMP Humber

39. On 1 June, Mr Sims was transferred from Lincoln to Humber. At a routine health screen, Mr Sims told a nurse that he had no thoughts of suicide or self-harm.

40. On 10 June, Mr Sims' cellmate found him with a ligature around his neck, making choking noises, and alerted staff. Mr Sims told an officer that he had done it because he was not able to talk to or see his family. He was crying and said that people in the prison were "after" him. An officer started ACCT procedures. A nurse saw Mr Sims and noted red marks around his neck. He told her that he had not intended to kill himself but that it was a cry for help. Mr Sims declined to see a Listener (a prisoner trained by the Samaritans to support other prisoners).

41. An officer assessed Mr Sims under ACCT procedures and concluded that Mr Sims was grieving for his brother and had relationship problems with his partner. Mr Sims denied thoughts of suicide and self-harm.

42. At the first ACCT case review that day, which was not multi-disciplinary, Mr Sims said that he had made the noose so that he could talk to someone. A custodial manager decided to continue ACCT monitoring for 24 hours, observing Mr Sims

once an hour. They assessed his risk as low and added three actions to his ACCT caremap, all for Mr Sims to complete. These were for him to apply for bereavement counselling, speak to the chaplain and attend the gym. The actions did not address his relationship issues, his lack of contact with his family, his fear for his safety or any mental health concerns.

43. An intelligence report dated 10 June noted that Mr Sims felt threatened by two prisoners on another wing, and should be transferred to avoid contact with them. This was not noted in his ACCT document, as it should have been.

44. At a second ACCT case review on 12 June, a Supervising Officer (SO) and an officer stopped ACCT monitoring as Mr Sims said he felt better able to deal with his feelings of grief and his relationship problems.

45. That day, Mr Sims' partner tried to visit him at Humber but, as she had previously asked not to have contact with him, she was not allowed to see him. Staff told her that she needed to confirm in writing that she now wanted to see him.

46. On 13 June, a member of the mental health team assessed Mr Sims. They recorded that Mr Sims was in a jovial mood and said he had no intention to kill himself. Mr Sims reiterated his statement that he put a ligature around his neck as a cry for help. The mental health team visited Mr Sims each day during the remainder of his time at Humber.

47. On 19 June, Mr Sims completed a post-closure ACCT review with an officer. He said that he still had relationship problems and was grieving his brother's death, but he felt better and no longer needed ACCT monitoring.

HMP Nottingham

48. On 21 June, Mr Sims was due to be transferred to Nottingham to attend court. He refused to go and damaged his cell. An officer telephoned the Head of Security at Nottingham to ask if he would accept Mr Sims. She told him that Mr Sims said that there were six prisoners at Nottingham whom he needed to avoid because of gang issues. He agreed that Mr Sims could move to Nottingham for his court appearance, but should be moved to a different prison afterwards. A nurse recorded that Mr Sims was fit to transfer to Nottingham, and Mr Sims' person escort record noted that his risk of violence would increase if he was moved to Nottingham as he had "violent associations". Mr Sims' person escort record did not refer to his recent suicide attempt at Humber or that he had recently been monitored under ACCT procedures.

49. An intelligence report dated 21 June said that Mr Sims spent about 30 minutes kicking the holding cell door when he arrived at Nottingham. The report noted that a custodial manager spoke to Mr Sims and he calmed down. An officer who worked in the first night centre and induction wing said that she saw Mr Sims on his first night. He said that he was upset about being at Nottingham at first but then calmed down and said that he was okay as he was in the first night centre rather than on a standard wing. The officer said Mr Sims did not tell her that he had recently been supported by ACCT procedures and she did not consider that he was at risk of suicide or self-harm. She said that staff assessed newly arrived

prisoners by what they said and their presentation and it was unlikely that staff considered prisoners' prison records or intelligence about them.

50. Mr Sims saw a nurse for a health screen. He denied thoughts of suicide and self-harm or any mental health problems. He did not tell her that he had recently been subject to ACCT monitoring or that he had tried to hang himself. The nurse said that when new prisoners arrived she was unable to look into their previous clinical notes until they had completed the reception health screen on the electronic medical record (SystmOne). She said she was not routinely given a copy of a prisoner's person escort record.

51. The nurse said she subsequently assessed Mr Sims' risk of suicide and self-harm based on his comments and her observations. She said that Mr Sims appeared "jolly" and did not indicate that he did not want to be at Nottingham. Humber did not send the ACCT document with Mr Sims, and Nottingham never saw Mr Sims' ACCT records from Humber.

52. On 22 June, an officer collected Mr Sims for court. He noticed that someone had written, "NOT TO RETURN TO HMP NOTTS" on the front of Mr Sims' person escort record. It is not clear who or when this was written but he checked with the Head of Operations and governor in charge of reception at Nottingham, who authorised that Mr Sims would return to Nottingham.

53. While waiting to appear at court, Mr Sims became threatening and aggressive to court staff and flooded his cell. Due to his behaviour, the court adjourned Mr Sims' case and decided to return him to Nottingham on remand. Mr Sims refused to go but the Head of Operations again authorised the transfer. He said that he did not know Mr Sims or that his person escort record had advised that he should not return to Nottingham after attending court. He said that many prisoners said they did not want to go to a particular prison but prisoners would return to the appropriate prison after court unless there were specific concerns. He said that the duty governor on 21 June had not made arrangements for Mr Sims to move to another prison.

54. Mr Sims was taken straight to the segregation unit at Nottingham because of his behaviour at court. A nurse said she assessed that he was not fit for segregation. While she did not remember the reasons for her decision, she said that her assessment was most likely based on Mr Sims' behaviour at court and her concern for his mental health. Nottingham did not provide us with any segregation paperwork and Mr Sims was not referred to the mental health team. Mr Sims was moved to the induction wing that day. An officer said that she saw Mr Sims in the segregation unit and he was calm. She said that, when he returned to the induction wing, he was okay and she had no concerns about him.

55. On 29 June, a nurse from Humber noted that she had left a telephone voicemail message for Nottingham's healthcare team to say that Mr Sims needed a mental healthcare assessment. It is not clear why Mr Sims never received a mental health assessment at Humber. Nottingham's healthcare team had no record of this message and never referred Mr Sims to the healthcare team.

56. On 1 August, the court adjourned Mr Sims' hearing.

57. On 4 August, a friend of Mr Sims' partner telephoned Nottingham to say that he was harassing his partner by calling her from a mobile phone. At around 1.45pm, security staff searched Mr Sims' cell. Mr Sims became aggressive to the officers and staff restrained him. Staff found a mobile phone on his person and a mobile phone charger in his cell. They moved Mr Sims to another cell under restraint.

6 August

58. On 6 August, Mr Sims attended a disciplinary hearing for having a mobile phone and charger. An officer noted that Mr Sims had wanted to apologise to the officers. The hearing was adjourned to 19 August to be heard by an independent adjudicator. Mr Sims asked what his likely punishment would be. He told him he might have some days added to his sentence. He said he was not concerned about Mr Sims' risk of suicide or self-harm.

59. Around 5.15pm, just before staff locked the cells for the night, an officer allowed Mr Sims at his request to make a brief telephone call to his partner. He asked to make a second call but she said that that he would have to wait until the next morning. The officer said that she had no concerns about Mr Sims' risk of suicide or self-harm. She said that she had never seen him under the influence of substances. She said staff knew his brother had died in custody and checked on him daily.

60. A prisoner who lived in the cell next to Mr Sims told the investigator that after they had been locked up for the night he spoke to Mr Sims through his cell wall about his (Mr Sims') relationship difficulties and football. Mr Sims said he would talk to him again in 20 minutes.

61. After approximately half an hour, the prisoner heard banging on their shared cell wall. He said that he heard Mr Sims' cell bell being pressed twice but nobody came, so he pressed his own cell bell. He did not know what time he did this. An officer answered his bell and he told him to check on Mr Sims' wellbeing. Nottingham has no cell bell records for D wing and we do not know how long staff took to answer.

62. The officer (who was not available to be interviewed by the investigator) wrote in his statement for the Governor that he had looked into Mr Sims' cell at 7.48pm and saw him at the back wall with a ligature round his neck, attached to the window bars. He radioed for help but did not use an emergency code. He went into the cell, took Mr Sims' weight, cut the ligature and lowered him to the floor. He placed him on his back and checked his breathing and pulse. As Mr Sims was not breathing, he started chest compressions.

63. Staff arrived at Mr Sims' cell within minutes. A SO radioed a medical emergency code blue at 7.52pm, and control room staff called an ambulance immediately. An officer took over chest compressions and a custodial manager attached a defibrillator to Mr Sims. (A defibrillator is an electric machine which can restart the heart in the right circumstances.)

64. Soon afterwards, two nurses arrived with the emergency bag and inserted an airway into Mr Sims' throat. One nurse took over compressions. The defibrillator advised to continue cardiopulmonary resuscitation, which staff did until

paramedics arrived at 7.59pm. After about 10 minutes, paramedics obtained a pulse from Mr Sims and took him to hospital.

Contact with Mr Sims' family

65. The night orderly officer (in charge of the prison overnight) started duty at 8.00pm. At 8.45pm, he tried to contact Mr Sims' sister, who was Mr Sims' next of kin. As her number was unobtainable, he contacted Mr Sims' partner who told Mr Sims' sister to call Nottingham prison, which she did. He told her that Mr Sims was in hospital.

66. At 9.35pm, hospital staff gave the officer who escorted Mr Sims to hospital a letter they found in Mr Sims' clothes. It indicated that his relationship with his partner had ended and that he intended to take his life. He asked that his father be contacted if he died. The officer subsequently telephoned Mr Sims' father to let him know what had happened. The prison family liaison officer supported Mr Sims' sister, and arranged for her to visit him in hospital.

67. Mr Sims died in hospital on 15 August, with his family present. Nottingham offered support to Mr Sims' sister and contributed to funeral expenses in line with national instructions.

Information after the incident of 6 August

68. On 7 August, a prisoner told an officer that two prisoners had been bullying Mr Sims for weeks because he had refused to pick up a package for them, and the mobile phone that staff found on Mr Sims belonged to one of them. He said that prisoners were bullying Mr Sims and his partner for money and a prisoner had told his partner that Mr Sims was HIV positive. The officer completed an intelligence report but said that she had not previously been aware that Mr Sims might have been bullied.

69. A prisoner told the investigator that Mr Sims had been smoking a lot of Mamba (NPS) and had been "bouncing around" on the wing.

Support for prisoners and staff

70. After Mr Sims' death, the Head of Safer Custody debriefed the staff involved in the emergency response to discuss any issues arising, and to offer support. The staff care team also offered support.

71. The prison posted notices informing other prisoners of Mr Sims' death, and offering support. Staff reviewed prisoners subject to ACCT procedures in case they had been adversely affected by Mr Sims' death.

Post-mortem report

72. A post mortem examination established that Mr Sims had died from hypoxic brain injury, asphyxiation by hanging and use of MDMA-CHMICA, a synthetic cannabinoid and NPS. The toxicology report showed that Mr Sims had MDMA-CHMICA in his system at the time of his death. It said that it was not clear when he had last used such compounds, but it might have affected his cognition at the

time of his hanging. Therapeutic levels of morphine and levetiracetam (which were not prescribed to Mr Sims) were also detected in his bloodstream.

Findings

Assessment of Mr Sims' risk of suicide and management of ACCT procedures

HMP Humber

73. Prison Service Instruction (PSI) 64/2011 on safer custody requires staff who have contact with prisoners to be aware of the risk factors and triggers for suicide and self-harm, and to take appropriate action. A prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. Intelligence indicated that Mr Sims had been involved in drug and gang culture in Lincoln. Mr Sims also had a number of other risk factors for suicide and self-harm:

- He had committed a violent offence against his partner.
- He had depression.
- He had relationship difficulties
- He was grieving for his brother who had taken his life in prison.

74. When Mr Sims tried to kill himself on 10 June, prison staff appropriately started ACCT procedures but did not operate them in line with national instructions. PSI 64/2011 expects continuity of case management and multi-disciplinary attendance of relevant people involved in the prisoner's care. This did not happen and no one from the healthcare team attended or contributed to Mr Sims' case reviews. Although a prisoner's risk should be assessed as raised if a prisoner has recently self-harmed, staff assessed Mr Sims' risk as low.

75. The PSI says that a caremap should reflect a prisoner's needs, level of risk and their triggers for distress. There should be detailed time-bound actions aimed at reducing the risk posed by the prisoner. The person(s) named against each of the actions required in the caremap must complete their actions by the date given. Caremaps should be reviewed and updated at each case review with new actions added if necessary and ACCT procedures should not be closed until all actions have been completed.

76. Mr Sims told staff that he had no contact with his family, had relationship issues, was grieving for his brother and feared for his safety. The caremap identified only one of these risk factors – his bereavement issues – and assigned each caremap action to Mr Sims to complete. The caremap did not address three out of four of his risk factors. He had said at the time he tried to take his life that prisoners were "after" him but staff failed to identify this as an issue to address. Although his risk factors were ongoing, staff stopped ACCT monitoring prematurely. Mr Sims had significant outstanding risk factors; staff should have identified his continuing and increased vulnerability and not stopped ACCT monitoring. We recommend that:

The Governor and Head of Healthcare of Humber should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance. In particular:

- **There should be a multi-disciplinary approach for all case reviews, with healthcare staff attending all first case reviews.**

- **ACCT caremaps should have specific, meaningful and time bound actions, aimed at reducing prisoners' risks to themselves, progress should be considered at each review and the caremaps updated if additional needs are identified. Staff should not close ACCT plans until all caremap actions have been completed.**
- **ACCT reviews should consider and record all available information and known risks factors when determining the level of risk of suicide and self-harm.**
- **ACCT reviews should fully consider and record the impact of bullying or intimidation on the risk of suicide and initiate appropriate action.**
- **The level of a prisoner's risk should be assessed as at least raised after an incident of attempted suicide or self-harm.**

77. When Humber transferred Mr Sims to Nottingham, they did not share all his known risk factors with Nottingham through his person escort record, including - most significantly - that he had recently tried to take his life and had been subject to ACCT monitoring until two days earlier. Although a nurse at Humber said that she left a message for the healthcare team at Nottingham to arrange a mental health assessment for Mr Sims, the team at Nottingham said they did not receive the message and they never identified that Mr Sims might have mental health issues despite information about this in his prison records. We recommend that:

When transferring prisoners, the Governor and Head of Healthcare at Humber should ensure that staff share all relevant information about risk, including a mental health needs, with the receiving prison and complete person escort records fully and accurately.

HMP Nottingham

78. PSI 07/2015 on early days in custody, says that reception staff must examine the person escort record and any other available documents to identify a prisoner's immediate needs or recorded risks. While we recognise that the person escort record did not note that Mr Sims' had attempted to take his life at Humber, this information was in his prison record and intelligence file. No one identified or considered these issues either at reception or later, when all relevant documentation was available, and Mr Sims was never supported by ACCT procedures at Nottingham.

79. The reception nurse said health screen nurses did not routinely receive a prisoner's person escort record and she was unable to look at Mr Sims' history on his computerised medical record until she had completed his assessment. She said she did not check Mr Sims' history after the assessment, and told us she only did so if she considered there was cause for concern. By not routinely checking Mr Sims' history, the reception nurse missed an opportunity to identify his recent self-harm.

80. Staff at Nottingham knew that Mr Sims was grieving because his brother had died in prison and that he had relationship issues. They were also aware that Mr Sims had behaved badly before his transfer to Nottingham and had said that he refused to go. Mr Sims' person escort record said that his risk of violence was increased at Nottingham because of his 'violent associations' and that he should

not return there after his court appearance. No one at Nottingham connected his poor behaviour, refusal to move to Nottingham, fear for his safety, recent ACCT procedures, difficult relationship with his partner and bereavement issues and identification of prisoners whom he feared to an increase in his risk of suicide and self-harm. No one addressed his concerns, put in place a plan to manage his risk or considered ACCT procedures. We would have expected Nottingham to build a picture of the issues affecting Mr Sims, and use it to support him appropriately. Staff repeatedly missed opportunities to assess Mr Sims' risk, including at reception and in the segregation unit, and provide appropriate support. We recommend that:

The Governor and Head of Healthcare at Nottingham should ensure that staff, including reception staff, consider, record and address all the known risk factors of a newly arrived prisoner when determining his risk of suicide and self-harm and start suicide and self-harm prevention procedures if necessary.

Mental health issues

81. Mr Sims was appropriately referred to the mental health team at Lincoln when he said at reception that he had depression and flashbacks about his brother's death. While Mr Sims never saw them and his depression was never addressed, it is reasonable that Lincoln's mental health team discharged Mr Sims from their caseload after he missed two appointments and declined their support (albeit after what appears from the records to be a brief conversation).

82. Although a nurse at HMP Nottingham assessed that Mr Sims was not fit to be segregated, he was never referred to the mental health team, as he should have been. This was another missed opportunity to support Mr Sims' potential mental health needs appropriately. We make the following recommendations:

The Head of Healthcare at Nottingham should ensure that staff refer prisoners to the mental health team where they have concerns about their mental health.

NPS, drugs, bullying and intimidation

83. We are concerned about the prevalence of NPS in prisons and the effect on the health and behaviours of those taking it. In July 2015, we published a learning lessons bulletin about deaths in which NPS was thought to play a factor. We highlighted several lessons to be learned, including the need for better awareness among staff of the dangers of NPS, more effective drug supply reduction strategies and better monitoring by drug treatment services.

84. Mr Sims' intelligence file and prison records noted that he had used NPS, was involved in drug and gang culture and had been punished under the violence reduction procedures at Lincoln. After his death, another prisoner and Mr Sims' sister told us that Mr Sims had used Mamba (an NPS) at Nottingham and his toxicology report found the presence of NPS and prescription drugs, which had not been prescribed to Mr Sims, in his body when he died. Despite this, there is no evidence that staff were aware that Mr Sims was using illicit substances at Nottingham.

85. Nottingham's violence reduction strategy sets out measures to support victims of bullying, threats and intimidation. It says that suspected bullying should be investigated and if necessary, escalated to the safer custody team who will allocate the case to a supervising officer for further investigation.

86. Bullying is a risk factor for suicide, and Mr Sims feared for his safety at Humber and at Nottingham. He told staff about his fear for his safety, behaved poorly several times and named the alleged perpetrators as he did not want to move to Nottingham. Despite this, there is no evidence that staff discussed or addressed his concerns. No one investigated the alleged bullying or challenged the alleged perpetrators' behaviour, even though Mr Sims had named the prisoners allegedly involved.

87. We note that at the 2016 inspection, HM Inspectorate of Prisons found that many prisoners at Nottingham did not feel safe, and we make the following recommendation:

The Governors of HMP Humber and HMP Nottingham should ensure that there is a co-ordinated approach to identifying indicators and risks of bullying and violent behaviour, including the impact of substances such as NPS. All allegations of violence, bullying or intimidation should be taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.

Emergency response

88. In line with Prison Service Instruction (PSI) 03/2013 on medical response codes, Nottingham's operational instruction, 02-2014, says that if a prisoner has breathing difficulties or is unconscious, a code blue should be called immediately. The officer who found Mr Sims hanged radioed for medical assistance and it took a further four minutes until a member of staff radioed a code blue. While we recognise that it is distressing for staff to find a prisoner hanged, it is critical that a code blue is called promptly in case a prisoner's life can be saved. This is not the first time that we have made a recommendation to Nottingham about emergency codes and we are concerned that we must repeat it again:

The Governor should ensure that that prison staff use the appropriate emergency medical code in a life threatening situation, and that control room staff request an ambulance immediately.

Clinical care

89. The clinical reviewer concluded that Mr Sims' care at Nottingham was not equivalent to that which he would have received in the community. She said that Mr Sims was failed by the lack of communication between two prison healthcare teams and a lack of information sharing between reception, healthcare and security staff. The clinical reviewer makes a number of recommendations which the Head of Healthcare at Nottingham will need to address.

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