

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Badr Rayan a prisoner at HMP Swinfen Hall on 8 May 2017

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*



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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 Rayan was found hanged in his cell at HMP Swinfen Hall on 8 May 2017. He was 20 years old. We offer our condolences to Mr Rayan's family and friends.

Staff at HMYOI Brinsford opened Prison Service suicide and self-harm prevention procedures in April 2017, but did not comply with some basic aspects of these procedures. When he was later transferred to Swinfen Hall, Mr Rayan spent much of his time alone in his cell. We are not satisfied that staff at Swinfen Hall supported him appropriately. Mr Rayan's case reviews, which should have considered his current risk of suicide and self-harm and sought ways to reduce that risk, were not multidisciplinary and did not put in place suitable plans to reduce his risk. We are concerned that staff did not consider all of the information available to them about Mr Rayan's risk and, therefore, underestimated his risk of suicide.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2018

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Summary

Events

1. On 7 June 2016, Mr Badr Rayan was remanded in custody to HMYOI Brinsford. In November, he was sentenced to ten years in prison. Prison staff managed him under Prison Service suicide and self-harm prevention procedures (known as ACCT) several times in his first months in prison, and he was frequently violent and abusive to staff and other prisoners.
2. On 26 April 2017, Mr Rayan cut his arm. Staff began ACCT procedures. At an assessment on 27 April, Mr Rayan said he wanted to be dead and spoke bizarrely about the devil and the outcome of his trial. A supervising officer led the first ACCT case review, but no healthcare representative attended and he did not create a caremap, both of which are mandatory requirements.
3. On 28 April, Mr Rayan was transferred to HMP Swinfen Hall. There was no ACCT case review before he left. A supervising officer led a case review shortly after Mr Rayan arrived at Swinfen Hall, but there was no healthcare representative. The reception nurse referred Mr Rayan to the prison's mental health team but, as it was a bank holiday weekend, no one assessed him until 2 May.
4. On 2 May, Mr Rayan told prison nurses that Satan had told him to harm himself and he had thought of ways to kill himself. Staff raised the frequency of his ACCT observations to a minimum of three per hour. The following morning, an officer found a piece of material in Mr Rayan's cell that might have been part of a ligature. At an ACCT case review later that day, a supervising officer again, without healthcare input, recorded that Mr Rayan was at low risk of harming himself and reduced the frequency of ACCT observations to a minimum of two per hour.
5. Mr Rayan spent most of the remainder of his life alone in his cell, rarely coming out other than to collect meals. Wing staff rarely had anything other than brief interactions with him, often did not complete ACCT observations at the required frequency and, when they did, the times of the checks were predictable.
6. At around 4.14am on 8 May, the night patrol officer found that Mr Rayan had obstructed his cell observation panel. The officer radioed for assistance and, when colleagues arrived at around 4.22am, they opened the cell and found that Mr Rayan had hanged himself. They called for emergency assistance and began cardiopulmonary resuscitation. Paramedics arrived and took Mr Rayan to hospital, where he died at 6.54am.

Findings

Management of risk - HMYOI Brinsford

7. We are concerned that there was no healthcare representative at Mr Rayan's first ACCT case review, particularly given his apparently bizarre behaviour at the assessment. This, as well as the requirement to create a caremap, is a mandatory requirement of the first case review. We are also concerned that

there was no case review before Mr Rayan's transfer to Swinfen Hall, and no consideration of the impact the transfer might have on the timeliness of assessment by a mental health professional.

Management of risk – HMP Swinfen Hall

8. Mr Rayan was isolated at Swinfen Hall, and we are concerned that the ACCT procedures did little to help him engage with the regime, with staff and with his peers. A number of key aspects of ACCT procedures aimed at reducing risk, including holding multidisciplinary case reviews and setting meaningful caremap actions, were not fulfilled. Mr Rayan's ACCT case manager did not fully consider information that might have indicated that he was at increased risk, and we are not satisfied that he made appropriate decisions about the level of Mr Rayan's risk and frequency of his observations. We also found that staff did not always record or carry out the observations at the specified intervals.

Emergency response

9. Swinfen Hall does not have a protocol which sets out what staff should do if they find a cell observation panel obscured. We found that the night patrol should have considered opening Mr Rayan's cell, rather than automatically waiting for colleagues to arrive.

Recommendations

- The Governor of HMYOI Brinsford should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
 - First case reviews are multidisciplinary and always include a member of healthcare staff.
 - ACCT caremap actions are initiated at the first case review, are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.
 - Case reviews are held before a prisoner subject to ACCT procedures is transferred, to make sure that any additional risks associated with the transfer have been considered and discussed with the prisoner.
- The Head of Healthcare of HMYOI Brinsford should ensure that continuity of healthcare is established when a prisoner subject to ACCT procedures is transferred.
- The Governor of HMP Swinfen Hall should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
 - ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff where relevant.
 - ACCT caremap actions are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.
 - Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.

- Observations and conversations are carried out as directed and documented in the ongoing record, with observations carried out at unpredictable intervals.
- The Governor should ensure that HMP Swinfen Hall has a protocol that instructs staff how to respond to obscured observation panels at night, including that they enter cells as quickly as possible if there is information that the prisoner may be at risk.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Swinfen Hall informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Swinfen Hall on 15 May 2017. He obtained copies of relevant extracts from Mr Rayan's prison and medical records, and interviewed one prisoner who knew Mr Rayan.
12. The investigator interviewed nine members of staff at Swinfen Hall in June and July, and two members of staff at HMYOI Brinsford on 21 June.
13. NHS England commissioned a clinical reviewer to review Mr Rayan's clinical care at the prison. The clinical reviewer joined the investigator for interviews with clinical staff.
14. We informed HM Coroner for South Staffordshire of the investigation who gave us the recorded cause of death. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Rayan's friend, who represented his family, to explain the investigation and to ask if the family had any matters they wished the investigation to address. Mr Rayan's friend did not raise any specific issues.
16. Mr Rayan's family and friend received a copy of the initial report. They did not make any comments.

Background Information

HMYOI Brinsford

17. HMYOI Brinsford holds up to 577 remanded and sentenced young adult men aged 18-21 across five residential units. Residential Unit 1, consisting of A Wing and C Wing, is a supported living unit for young men who find it difficult to adapt to prison life. Care UK provide healthcare services.

HM Inspectorate of Prisons

18. The most recent inspection of HMYOI Brinsford was in February 2015. Inspectors reported that incidents of self-harm had reduced by a third since their previous inspection and the quality of ACCT documents had greatly improved.

Independent Monitoring Board

19. 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 the year to July 2016, the IMB reported that ACCT case reviews were thorough and prisoners subject to ACCT procedures received appropriate attention from staff.

Previous deaths at HMYOI Brinsford

20. One prisoner has died at Brinsford since January 2015. Our investigation into his death found that the first ACCT case review was not multidisciplinary and did not include a member of healthcare staff.

HMP Swinfen Hall

21. HMP Swinfen Hall holds up to 624 young adult men aged 18 to 28, who are serving sentences of over four years. It has nine wings and the majority of cells are single. Care UK is the lead healthcare provider. Nurses are on duty everyday, but there is no healthcare cover at night. Mental health nurses work from Monday to Friday.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Swinfen Hall was in October 2016. Inspectors reported that a number of prisoners said they felt suicidal, although the number of incidents of self-harm had fallen since their last inspection. They found that the quality of case management for prisoners in crisis was inconsistent, and that too many such prisoners, including those in their first days at the prison, spent long periods in their cells with little to do. Inspectors found that staff monitoring entries for prisoners subject to ACCT procedures were not sufficiently frequent and did not demonstrate meaningful engagement.

Independent Monitoring Board

23. In its latest annual report, for the year to April 2016, the IMB reported that prison staff had opened more ACCT documents than in the previous year, although the number of incidents of self-harm had decreased.

Previous deaths at HMP Swinfen Hall

24. Mr Rayan is the third prisoner to take his own life at Swinfen Hall since March 2014. In our investigation into the first of these deaths, we found that ACCT case reviews were not always multidisciplinary and prison staff did not carry out observations as directed.

Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Background

26. Mr Rayan said that he was born in Palestine and moved to Spain when he was six years old. This was not confirmed, and other information suggested Mr Rayan was Moroccan. (Two prison nurses at HMP Swinfen Hall, also said that Mr Rayan told them he was from Morocco.) In 2009, when he was 12 years old, he came to the United Kingdom illegally. Mr Rayan applied for asylum, but the Home Office refused this application and a second application for further leave to remain that he made in 2014.
27. In February 2016, Mr Rayan was remanded to HMYOI Brinsford, having been convicted of criminal damage and assault. This was his first time in prison. Mr Rayan was released three weeks later.

HMYOI Brinsford

28. On 7 June 2016, Mr Rayan was remanded to Brinsford, charged with racially aggravated assault. At a reception health screen, a nurse recorded that Mr Rayan was a heavy drinker and used cannabis and amphetamines. Mr Rayan did not describe any history of mental health diagnosis, treatment or symptoms. The nurse recorded that she had no concerns about Mr Rayan's risk of harming himself.
29. Mr Rayan's first months in custody were difficult. He was violent and abusive towards staff and fellow prisoners, and threatened to kill and assault staff. Prison staff began ACCT procedures for ten days in June, when Mr Rayan violently banged his head on his cell door.
30. Prison staff began ACCT procedures for a second time on 24 August, as Mr Rayan urinated in his cell and refused to engage with them. A consultant psychiatrist assessed Mr Rayan on 26 August. He did not make a mental health diagnosis and did not recommend treatment. Prison staff stopped ACCT monitoring on 1 September.
31. Mr Rayan's poor behaviour continued in September and October, and staff began ACCT procedures again on 21 October, when he set a fire in his cell. They stopped ACCT monitoring four days later.
32. The remainder of the year was quieter for Mr Rayan, although he was still occasionally abusive to staff. On 24 November, he was sentenced to ten years in prison. This meant that he was no longer eligible for Brinsford, which takes prisoners with a maximum sentence of four years, although he would remain at the prison until a place became available at an appropriate establishment, where he could work towards the objectives in his sentence plan.
33. On 28 January 2017, Mr Rayan twice set fires in his cell, saying he wanted staff to help him change his solicitor. (There is no record that anyone advised Mr Rayan how to change his solicitor.) February and March were quieter months for Mr Rayan, with no recorded incidents of anti-social behaviour.

Opening ACCT procedures

34. At around 9.30pm on 26 April, Mr Rayan told the night officer that he had cut his forearm. The night officer began ACCT procedures.
35. On 27 April, a safer custody business administrator assessed Mr Rayan. She recorded that Mr Rayan said he cut his arm because he wanted to be dead due to having been in prison for a year. (Mr Rayan had in fact been in custody for ten and a half months at the time.) She also recorded that Mr Rayan spoke bizarrely, said that he was innocent and had “made a deal with the Devil”. The safer custody administrator also told us that Mr Rayan thought that Jews were persecuting him. Mr Rayan said that he would refuse to eat until he died. She recorded two action points to take from the meeting: for Mr Rayan to speak to his solicitor, and for prison staff to refer him to the mental health team.
36. Shortly afterwards, a Supervising Officer (SO) led the first ACCT case review, with the safer custody business administrator and Mr Rayan. No healthcare representative attended. The SO told us that he was asked to hold the case review at short notice and he did not therefore have the opportunity to invite a healthcare representative. He recorded that Mr Rayan was “ranting” and appeared unable to control his thought process. The SO noted that he would arrange a second case review for the next day, to which he would invite a representative of the prison’s mental health team. He did not complete a caremap, and told us that this was because Mr Rayan did not raise any specific issues and was mostly rambling and ranting. The SO concluded that Mr Rayan’s risk of suicide and self-harm was raised (on a scale of low, raised or high) and set ACCT observations at a minimum of one per hour.
37. Mr Rayan ate lunch on 27 April, but refused his evening meal and told prison staff that he was not hungry. An officer recorded that Mr Rayan’s behaviour was bizarre that day, and he said he had vomited “in the shape of Christianity” and that Satan was in his head.
38. Mr Rayan was due to transfer to HMP Swinfen Hall on 28 April. Both the SO and the safer custody business administrator said they did not know this at the time of the ACCT case review the previous day. In the morning, the safer custody business administrator emailed the safer custody team at Swinfen Hall and outlined what Mr Rayan had said and how he had acted at the assessment and case review. She wrote that prison staff would hold an ACCT case review before Mr Rayan’s departure, although this did not happen.
39. Prison staff did not record whether Mr Rayan had breakfast on 28 April, but noted that he ate lunch. At lunchtime, Mr Rayan asked an officer if he could speak to his solicitor. The officer told him to wait until after lunch. It does not appear that Mr Rayan was able to telephone his solicitor before his transfer.

HMP Swinfen Hall

40. Mr Rayan left Brinsford at around 2.30pm, and arrived at Swinfen Hall at around 3.45pm. Nurse A, the clinical lead, assessed Mr Rayan shortly after his arrival and recorded that he said he had not eaten for two days in an attempt to die. Mr Rayan said he was not guilty of his offence and that was why he wanted to die.

He refused a blood sugar test but agreed for her to refer him to the mental health team. Nurse A created a food refusal care plan and recorded that Mr Rayan was at high risk of harming himself.

41. Later in the afternoon, an officer held a first night interview. He recorded that Mr Rayan was not happy to be at Swinfen Hall and said he would not eat as a protest of his innocence. No one recorded whether Mr Rayan ate his evening meal. He was assigned a cell on B Wing, the prison's induction unit.
42. At around 6.30pm, an SO held an ACCT case review, with Officer A and Officer B. There was no healthcare representative. The SO recorded that Mr Rayan said he had no thoughts of self-harm but would not eat to protest his innocence. He told us that Mr Rayan was not happy about his sentence, believed himself to be innocent, and said he needed to speak to someone about this. The SO noted that Mr Rayan said he could hear voices and that Nurse A had referred him to the mental health team. He concluded that Mr Rayan's risk of suicide and self-harm was low, and that he should remain on a minimum of one observation per hour. He also recorded that prison staff should hold at least three quality conversations with Mr Rayan each day.
43. The SO entered four actions on the ACCT caremap: for staff to refer Mr Rayan to the mental health team (which he ticked as having been completed); for wing staff or Mr Rayan to refer him to the prison's Imam; for Mr Rayan to write to his solicitor; and for Mr Rayan to contact the Offender Management Unit to discuss his sentence plan.
44. On 29 April, Mr Rayan refused both lunch and evening meal. On 30 April, he ate lunch, although there is no record of whether he ate breakfast or evening meal. In the evening, Mr Rayan said he would like to speak to his solicitor. As the prisoners were locked in their cells for the night, an officer told Mr Rayan that he should speak to wing staff in the morning. There is no record that he did.
45. No one recorded whether Mr Rayan ate anything on 1 May. On 2 May, he asked for some noodles in the morning, and then ate lunch afterwards. Mr Rayan then began to eat meals consistently.
46. That afternoon, Nurse B and Nurse C assessed Mr Rayan. Nurse B told us that Nurse A had not completed the referral correctly (28 April was Nurse A's first day working at Swinfen Hall) and the mental health team were not therefore aware of his referral until 2 May. As 2 May was the first working day after a bank holiday weekend, Nurse B did not think that a mental health practitioner would have seen Mr Rayan any earlier had Nurse A completed the referral correctly (there is no mental health service provision at Swinfen Hall at weekends or bank holidays).
47. Nurse C recorded that Mr Rayan said that Satan spoke to him and told him to harm himself. Mr Rayan said he had thought of ways to kill himself and spoke about hanging. Nurse B recorded that it was hard to follow Mr Rayan's train of thought and to assess his mental capacity. She made an appointment with the visiting psychiatrist for 9 May, and recorded Mr Rayan's comments in the ACCT document.

48. After the assessment, Nurse C and Nurse B spoke to Officer B, who agreed to increase the frequency of observations to a minimum of three per hour. Officer B spoke to the SO, who completed the change on the ACCT document.
49. At around 8.10am on 3 May, Officer B found an eight-inch long piece of bedding material wedged in the top corner of Mr Rayan's cell door. She and a colleague removed the material and tried to speak to Mr Rayan about it, but he did not respond. She recorded this in the ACCT document.
50. Later in the morning, a prison GP reviewed Mr Rayan. He recorded in the medical record that Mr Rayan thought Satan spoke to him and had considered hanging himself. The GP did not make an entry in the ACCT document. He said he was not aware that Mr Rayan was being monitored under ACCT procedures. (It is a mandatory national instruction that the ACCT document must travel with the prisoner throughout the prison, to ensure that staff are informed of the prisoner's risk status and are able to input into the document.)
51. A nurse then saw Mr Rayan in follow-up to his food refusal. Mr Rayan said he had refused food because he was unhappy with his sentence and wanted to appeal but did not know how. Mr Rayan also said his solicitor, who he did not think liked him, had annoyed him. She suggested that Mr Rayan should contact the IMB for advice.
52. On his return to B Wing, Mr Rayan told an officer that he was not happy with his court proceedings, and asked for an application form to raise an issue with the IMB. The officer advised him to contact his solicitor instead. That afternoon, an SO introduced himself to Mr Rayan as his offender supervisor. Mr Rayan said he wanted to change his solicitor and appeal his conviction and sentence. The SO told him how to contact a new solicitor.
53. In the evening, an SO held an ACCT case review. He recorded that Officer B was also present but healthcare staff were unavailable. The SO noted that Mr Rayan appeared more settled, although he said he still heard voices. Mr Rayan said he wanted to see someone from the Offender Management Unit about his sentence. The SO made no record that he discussed or considered either Mr Rayan's comments to Nurse B and Nurse C or the material Officer B found in his cell. He told us that he spoke to Mr Rayan about using distraction techniques when he heard voices, but said he did not know about the material found. The SO recorded that Mr Rayan's risk of suicide and self-harm was low, but told us he meant by this that the risk was slightly lower than before although still raised overall. He reduced the observations to a minimum of two per hour.
54. Officer B told us that she was not at this case review, but that the SO spoke to her afterwards about the level of observations. She said that he asked her about putting Mr Rayan on one observation per hour, but she thought that two was more appropriate given what he had said to the nurses the previous day. The SO said he thought Officer B was present throughout the case review.
55. On 5 May, Nurse A reviewed Mr Rayan. She recorded that he appeared distracted and gave one-word answers to her questions. She noted that Mr Rayan did not appear distressed and did not speak of any thoughts of harming himself. She asked wing staff to monitor Mr Rayan over the weekend (5 May

was a Friday) and contact healthcare staff if they had any concerns about his presentation.

7 May 2017

56. Although prison staff should have observed Mr Rayan a minimum of twice per hour, CCTV footage shows that they frequently failed to meet this requirement on 7 May, and there were some periods of over an hour in which no one went to Mr Rayan's cell.
57. In the morning, Mr Rayan chose to stay in his cell when other prisoners spent time in the open air. At around 2.00pm, Officer C went to Mr Rayan's cell to escort him to the healthcare centre for an appointment. Officer D joined her at the cell, but CCTV footage shows she did not appear to speak to Mr Rayan. Officer C said that Mr Rayan told her to "fuck off" and said he did not want to go to the appointment. She reported this to the SO, who went to the cell and spoke to Mr Rayan. Mr Rayan again said he did not want to go to the healthcare centre.
58. The SO telephoned the healthcare centre, and a nurse decided to visit Mr Rayan in his cell. She arrived at around 2.20pm, and spent seven minutes in the cell. Officer D unlocked the cell and appeared to speak briefly to Mr Rayan before standing outside the cell for most of this time. The nurse recorded that Mr Rayan said he did not think the psychiatrist would be able to help with the "spirit in his head" and that he wanted to speak to someone about his appeal. She asked Mr Rayan if he had contacted the IMB, as she had advised earlier in the week. Mr Rayan said he did not understand what to do and that the officers had not helped him. The nurse told us that she spoke to an officer after the assessment, who said Mr Rayan had submitted an application to the IMB. The Chair of Swinfen Hall's IMB told us that they did not receive an application from Mr Rayan.
59. After Mr Rayan's death, a prisoner in a neighbouring cell told the police that Mr Rayan told Officer D he wanted to kill himself when she went to his cell that afternoon. The prisoner said that Officer D replied that he should "do it quietly". Another prisoner told the police that neither Officer D nor Officer C said this to Mr Rayan, and that the first prisoner had tried to pressure him not to support staff in the matter. The prisoner also told prison staff that the first prisoner was "pissed off" with Officer D and was therefore making up a story that she had bullied Mr Rayan. A third prisoner supported this account. Officer D said the first prisoner's account was untrue, and both Officer C and a nurse said they did not hear Mr Rayan threaten to take his life or anyone say anything abusive to him.
60. Later in the afternoon, most prisoners came out of their cells for a period of association (when prisoners are allowed to socialise with each other on their wing), but Mr Rayan chose to remain in his cell. At around 4.20pm, Mr Rayan came out of his cell briefly to collect his evening meal, after which he and all other prisoners were locked in their cells for the night.
61. Officer C completed an ACCT observation at 4.30pm. In the evening, Officer E was the sole member of staff on duty. He completed just two observations, at 6.00pm and 7.20pm. Officer E said he could not remember why he did not complete the required observations, but speculated that he was catching up on work he had not been able to complete earlier in the day.

Emergency response

62. At 8.45pm, an operational support grade (OSG) relieved Officer E. He completed ACCT observations around every half an hour during the night. At around 4.14am, he found that Mr Rayan had covered the observation panel with newspaper. He knocked on the door and called to Mr Rayan, but he did not respond.
63. The OSG then radioed the night manager and explained what he had found. The night manager and two officers went to Mr Rayan's cell, and arrived at around 4.22am. They opened the cell, and found Mr Rayan hanging from a ligature made from bed sheet that he had tied to the hinge on the door. The night manager cut the ligature and radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator called an ambulance immediately.
64. An officer began chest compressions, and rotated with the night manager after he had organised other staff to escort the paramedics to the cell. They attached a defibrillator, which found no shockable heart rhythm. The staff continued chest compressions until paramedics arrived at around 4.45am.
65. At around 5.30am, the paramedics took Mr Rayan to the hospital. At 6.54am, hospital staff confirmed that he had died.

Contact with Mr Rayan's family

66. Mr Rayan did not name a next of kin and prison staff could not trace any of his family after his death. Some weeks after his death, a friend of Mr Rayan's family contacted Brinsford on their behalf to enquire about his wellbeing. A family liaison officer telephoned him and told him of Mr Rayan's death. Mr Rayan's friend contacted his family (who live in Spain and do not speak English) and passed the news to them.
67. Swinfen Hall contributed to the cost of Mr Rayan's funeral in line with Prison Service instructions.

Support for prisoners and staff

68. After Mr Rayan's death, the deputy governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
69. The prison posted notices informing other prisoners of Mr Rayan's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Rayan's death.

Post-mortem report

70. HM Coroner for South Staffordshire did not request a post-mortem examination. Hospital specialists gave the cause of death as cardiopulmonary arrest due to strangulation.

Findings

Management of risk of suicide and self-harm

71. Prison staff managed Mr Rayan under ACCT procedures – first at Brinsford and then for 11 days at Swinfen Hall before he hanged himself. We are concerned that these procedures were poorly managed and did little to support him. While this might not have affected the eventual outcome for Mr Rayan, it would have given prison managers and staff a better chance of producing a co-ordinated and effective care plan, aimed at addressing his issues and reducing his risk.

HMYOI Brinsford

72. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It requires ACCT case reviews to be multidisciplinary where possible and says that, for the first case review, a healthcare representative must attend. There was no healthcare representative at Mr Rayan's first case review and no evidence that healthcare staff were consulted for their input. This is concerning, particularly given Mr Rayan's seemingly bizarre comments at the assessment and the highlighted requirement for a referral to the mental health team.
73. In our investigation into the death of a prisoner at Brinsford in December 2015, we found that the first ACCT case review was only attended by wing staff, and we recommended that the Governor ensure that all first case reviews were multidisciplinary and always included a member of healthcare staff. The Head of Safety at Brinsford told us of several initiatives they have since implemented to ensure that ACCT case reviews are multidisciplinary, including holding case reviews at set times so that staff can more easily schedule them into their day.
74. The SO who led Mr Rayan's first case review told us that prison managers have persistently reminded ACCT case managers that healthcare representation is mandatory at the first case review. Nevertheless, he said he was asked to lead Mr Rayan's first case review late in the day at short notice and there was not therefore anyone from healthcare available to attend. He planned to hold a case review the next day which staff from the mental health team would attend but, because of Mr Rayan's transfer, this did not happen.
75. It is encouraging that staff at Brinsford have taken steps to learn from our previous investigation. However, the lack of healthcare representation at Mr Rayan's first case review should have been avoidable with better communication. Given that the ACCT procedures were opened overnight, there should have been time in the morning to appoint a case manager, set a time for the first case review and invite appropriate attendees.
76. A caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview. The caremap should set time bounded actions and be aimed at reducing the risk the prisoner presents to themselves. The SO did not complete a caremap at Mr Rayan's first case review. He told us this was because Mr Rayan did not raise any specific issues and was

mostly rambling and raving at the case review. However, the safer custody business administrator recorded at the assessment that Mr Rayan needed to speak to his solicitor and was concerned about his conviction, and this should have been addressed through the caremap. The referral to the mental health team should also have been included in the caremap, so prison staff could check Mr Rayan's progress at later case reviews and ensure he had seen the relevant healthcare professionals.

77. When she learnt of Mr Rayan's impending transfer to Swinfen Hall, the safer custody administrator appropriately contacted their safer custody team to alert them to Mr Rayan's arrival and his recent actions. The SO had scheduled a case review for 28 April and the safer custody business administrator noted in her email to Swinfen Hall that Brinsford staff would hold a case review before the transfer, but this did not happen.
78. PSI 64/2011 highlights that transfer between prisons is a known trigger for suicide and self-harm. We consider that Brinsford staff should have held an ACCT case review before Mr Rayan left the prison. This should have considered whether he was well enough to transfer and whether any additional measures, such as an increased frequency of observations, were required to offset the increased risk associated with transfers.
79. There was no contact between healthcare services at the two prisons before Mr Rayan's transfer. No one considered the impact of transferring Mr Rayan immediately before a bank holiday weekend and the potential this had to delay his assessment by a mental health professional. In our Learning Lessons Bulletin about the self-inflicted deaths of young adults, we identified that the impact of significant disruption on the wellbeing and safety of already vulnerable prisoners should be fully considered in transfer decisions. We make the following recommendations:

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

- **First case reviews are multidisciplinary and always include a member of healthcare staff.**
- **ACCT caremap actions are initiated at the first case review, are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.**
- **Case reviews are held before a prisoner subject to ACCT procedures is transferred, to make sure that any additional risks associated with the transfer have been considered and discussed with the prisoner.**

The Head of Healthcare of HMYOI Brinsford should ensure that continuity of healthcare is established when a prisoner subject to ACCT procedures is transferred.

HMP Swinfen Hall

Case review on 28 April

80. An SO appropriately held an ACCT case review shortly after Mr Rayan arrived at Swinfen Hall. The review panel consisted of wing staff only and there is no evidence that healthcare staff were consulted for their input. The SO set four caremap actions at the case review, but these amounted to referrals to services and individuals only and other than the mental health referral that Nurse A had already completed, all were left for Mr Rayan himself to complete. Mr Rayan frequently asked for help contacting a solicitor and his belief in his innocence appeared to be one of the most significant aspects of his distress, yet he did not receive any effective support with this through the ACCT process.

Case review on 3 May

81. On 2 May, prison staff appropriately increased the frequency of ACCT observations when Mr Rayan said he had thought of ways to kill himself, and spoke about hanging and hearing voices that told him to kill himself. An SO held a case review the next day and recorded that Officer B was also present, although the officer told us that this was not correct. Again, there were no healthcare staff present, despite Mr Rayan's mental health issues. There is no evidence that the SO discussed Mr Rayan's comments of the previous day, and he told us that he was not aware of the piece of material Officer B found in Mr Rayan's cell that morning (which, given her description, we think likely to be either a failed or practice ligature), despite both events being recorded in the ACCT document.
82. The SO reduced the frequency of observations and recorded that Mr Rayan was at low risk of suicide and self-harm. He told us that he meant that Mr Rayan's risk was lower than previously but still raised overall. This is not a correct interpretation of the purpose and outcomes of risk assessment.
83. Guidance in the ACCT document is that risk is high when a prisoner has frequent suicidal ideas that are not easily dismissed, there is a specific plan with likely access to lethal methods, and there is evidence of acute or ongoing mental illness. We consider that the SO should have assessed Mr Rayan's risk of suicide and self-harm as high at the case review on 3 May and, rather than reducing the frequency of observations, considered increasing the frequency.
84. Following Mr Rayan's death, the deputy governor commissioned a disciplinary investigation into the SO's performance and removed him from involvement in the ACCT process.

Completing and recording observations and conversations

85. PSI 64/2011 states that staff must follow the level of observations and conversations noted on the ACCT document and must record these immediately or as soon as is practical. It also states that staff must actively engage with the prisoner, encouraging them to talk and participate in activities where appropriate.
86. There is no evidence that wing staff held good quality conversations at the required frequency of three per day, and most of their interaction with Mr Rayan

was brief. Mr Rayan spent nearly all of his time at Swinfen Hall isolated in his cell, and he did not have any visits or telephone calls to family or friends. Mr Rayan was a vulnerable and suicidal young man and, in these circumstances, it was particularly important that staff should have tried to engage with him.

87. Although Mr Rayan should have been observed at least twice an hour, wing staff recorded observations much less frequently. All of the staff we spoke to said that local practice at Swinfen Hall was to record a summary of observations several times a day, rather than to record all observations. Swinfen Hall does have a local protocol (Information to Staff 72/2016) that allows this, but only for prisoners on a high frequency of observations (five per hour is cited as an example). This local protocol is inconsistent with the mandatory requirement of PSI 64/2011 that all observations are recorded.
88. CCTV footage of 7 May shows that staff observed Mr Rayan much less frequently than the required minimum of twice an hour. There were several occasions in which over an hour passed between observations, the longest period being around one hour and 40 minutes. While we appreciate that prison staff are busy, failure to provide the required monitoring of prisoners at risk of suicide and self-harm will increase their risk and completing these observations should be a priority. It is possible that the local practice of summarising observations has contributed to this failure to complete all observations.
89. On the night of 7 to 8 May, an operational support grade checked Mr Rayan around every 30 minutes. PSI 64/2011 instructs that observations must be completed at unpredictable intervals, so that the prisoner cannot predict when they will be checked and plan around this. On the night of his death, it is likely that Mr Rayan could anticipate when the OSG would check him next.
90. In a PPO Learning Lessons Bulletin, published in March 2015, about the self-inflicted deaths of prisoners in 2013-14, we found that staff should ensure that prisoners at risk of suicide and self-harm are managed in line with national instructions and guidance. We found that this should include holding multidisciplinary case reviews, completing relevant caremap objectives and ensuring observations follow the prescribed level.
91. Our findings echo those in our investigation into the self-inflicted death of a prisoner at Swinfen Hall in March 2014, in which we found that ACCT case reviews were not always multidisciplinary and that observations were not completed at the required frequency or unpredictability. We make the following recommendation:

The Governor of HMP Swinfen Hall should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff where relevant.**
- **ACCT caremap actions are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.**

- **Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.**
- **Observations and conversations are carried out as directed and documented in the ongoing record, with observations carried out at unpredictable intervals**

Allegation from prisoner

92. A prisoner in a neighbouring cell told the police that Mr Rayan told Officer D that he wanted to kill himself, and she replied that he should “do it quietly”.
93. Another prisoner told the police that this had not happened and the first prisoner had pressured him not to support Officer D. He also told prison staff that the first prisoner had made up the story because he was “pissed off” with Officer D. A third prisoner supported this account.
94. CCTV footage shows that Officer D was present at the time of the incident, but she spent nearly all of this time outside Mr Rayan’s cell and only appeared to speak to him briefly when unlocking the cell for a nurse. None of the staff present, including Officers D and C, and the nurse, said they heard any of the things that the prisoner alleged.
95. While it is not possible to know exactly what happened, we are satisfied that there is no corroborative evidence to support the prisoner’s account that Officer D was abusive to Mr Rayan.

Emergency response

96. Swinfen Hall does not have a local protocol to tell staff what to do if they find a cell observation panel obscured. The operational support grade said that he had not received any training on how to manage such a situation, but said that his understanding of best practice is to try to get a response from the prisoner and then radio the night manager for assistance. He said he would not enter a cell in these circumstances until he could hear other staff coming onto the wing.
97. Around eight minutes passed from when the operational support grade found the observation panel obscured until the night manager opened the cell. At night, officers have a key in a sealed pouch for use in an emergency.
98. Prison Service Instruction 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid, dynamic risk assessment. PSI 24/2011 also states that, where observation panels are covered, a decision by a member of staff to enter the cell immediately on their own will be more difficult as there is less evidence to inform an immediate risk assessment.

99. We appreciate that staff are faced with difficult decisions in circumstances such as these. As Mr Rayan was being managed under ACCT procedures, the operational support grade was aware that he had been identified as at risk of suicide and self-harm. In light of this, he should have considered immediately trying to open the cell. We make the following recommendation:

The Governor should ensure that HMP Swinfen Hall has a protocol that instructs staff how to respond to obscured observation panels at night, including that they enter cells as quickly as possible if there is information that the prisoner may be at risk.

**Prisons &
Probation**

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