Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Connell a prisoner at HMP Hindley on 20 February 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.

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

Mr Stephen Connell died in hospital, on 20 February 2016, two days after staff found him hanged in his cell at HMP Hindley. He was 20 years old. I offer my condolences to Mr Connell's family and friends.

Mr Connell was a challenging prisoner and his behaviour brought him into conflict with other prisoners, with allegations and counter-allegations of bullying which staff sought to address. However, he was also vulnerable and, at various times, at risk of suicide and self-harm. I am, therefore, concerned that staff did not properly consider information in Mr Connell's escort document and medical record about his risk of suicide and self-harm when he first arrived at Hindley. When he was later identified as at risk, the suicide and self-harm prevention procedures were not managed in line with national instructions. In spite of the deficiencies, I do not consider that prison staff could have identified that Mr Connell was at high or imminent risk of suicide immediately before his death.

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 **November 2016**

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Summary

Events

1. On 6 January 2015, Mr Stephen Connell was sentenced to eight weeks in prison, for failure to comply with a community order, and sent to HMP Altcourse. (While serving this sentence, he was remanded for further offences of aggravated vehicle taking and burglary. He was subsequently convicted and sentenced to 16 weeks and 28 months, respectively.) At his initial health screen, Mr Connell said that he had attempted to hang himself in 2008 and that he used drugs daily, including new psychoactive substances (NPS).

2. At Altcourse, prison staff monitored Mr Connell for two short periods in February and May 2015, using the Prison Service suicide and self-harm prevention procedures, known as ACCT. On each occasion, he had threatened to harm himself to force a move to another cell. Staff closed both ACCTs within 24 hours.

3. Mr Connell was transferred to HMP Hindley, from HMP Altcourse, on 30 October 2015. His escort record clearly stated that he had attempted to hang himself in 2008 and his medical record contained entries about previous threats of suicide. At his health screen and interviews with reception staff, Mr Connell said he had no thoughts of suicide or self-harm.

4. On 4 November, another prisoner assaulted Mr Connell and staff placed him on a formal support plan for prisoners considered to be vulnerable, but not at risk of suicide or self harm.

5. Prison staff monitored Mr Connell under ACCT from 6 December to 23 December, after he took an overdose of paracetomol. He alleged that he was under threat from other prisoners as he was in debt and he felt low as he had no family contact.

6. Mr Connell continued to use drugs in prison but declined support from substance misuse services. He had difficult relationships with staff and prisoners and was often verbally and physically abusive. Due to his behaviour, he spent extended periods on the basic level of the prison regime. Mr Connell became withdrawn and mostly remained in his cell, refusing to attend work or socialise with other prisoners. Mental health assessments concluded that he did not need support from the mental health team.

7. At 11.40am, on 18 February, staff found Mr Connell hanged in his cell by a piece of torn bedding tied to the window bars. An officer radioed an emergency medical code and the control room called an ambulance immediately. Other staff arrived quickly and attempted to resuscitate Mr Connell, but he remained unconscious. Paramedics took Mr Connell to Wigan Infirmary, where he remained in intensive care until his death on 20 February.

Findings

8. There is no evidence that reception staff at Hindley actively considered the information recorded about Mr Connell's previous attempts at suicide and self-harm when he arrived at Hindley.

9. We are also concerned that Mr Connell's period of monitoring under ACCT was poorly managed. There was no healthcare input at the initial ACCT case review, although this is a mandatory requirement for all first case reviews. Caremaps were not updated and staff closed the ACCT procedures before completing all the actions listed.

10. We are satisfied that staff investigated Mr Connell's claims of bullying and that he was appropriately reviewed at safeguarding meetings. Although there were instances of conflict with other prisoners, the investigation found no evidence that Mr Connell was deliberately targeted.

11. The clinical reviewer is satisfied that Mr Connell received appropriate healthcare support at Hindley and his care was equivalent to that he could have expected to receive in the community.

12. In spite of our concerns about weaknesses in assessing Mr Connell's risk and the management of the ACCT procedures, there was little to indicate that Mr Connell was at high or imminent risk of suicide and we are satisfied that staff could not have predicted or prevented his death.

Recommendations

- The Governor should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm. When they decide not to begin ACCT procedures for prisoners with significant risk factors, or who arrive with suicide and self-harm warning forms, PER information they should clearly record the reasons.

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:
    - A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.
    - Setting effective caremap objectives, which are specific and meaningful, aimed at reducing risk; ensuring that staff update caremaps during reviews**;** and that ACCTs are not closed before all caremap actions have been completed.

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The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Hindley informing them of the investigation and asking anyone with relevant information to contact him. One prisoner wrote to him stating that he had information that might assist our investigation, which he would share, subject to payment. He replied to explain that this would not be possible, and asked him to reconsider. No response was received. He passed the prisoner's details to Greater Manchester police so that they could interview him.

14. The investigator visited Hindley and obtained copies of relevant extracts from Mr Connell's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Connell's clinical care at the prison.

16. The investigator interviewed 19 members of staff at Hindley. He and the clinical reviewer interviewed several of the healthcare staff together. He also obtained police witness statements by staff and prisoners.

17. We informed HM Coroner for Bolton of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. One of our family liaison officers contacted Mr Connell's father and the friend Mr Connell had named as his next of kin to explain the investigation. They had several questions and concerns:

    - They believed that Mr Connell had recently self-harmed and said he had visible cuts to his arms when they visited him in hospital. They asked whether anyone had seen these cuts, and if the decision to close the ACCT was appropriate?
    - They asked if there was any evidence that Mr Connell had said he would end his life if he was not given a TV and, if so, whether staff took the right action?
    - They asked if Mr Connell's behaviour had changed after an incident in December 2015 and whether he had been segregated?
    - They wanted to know his status under the prison's Incentives and Earned Privileges (IEP) scheme and whether this had reduced his access to money, cigarettes and in-cell TV.

19. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

20. Mr Connell's family received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that we do not feel impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Hindley

21. HMP Hindley was formerly a young offender institution. In 2015, it became a category C prison for adult men sentenced to less than four years and young adults aged 18-21, serving sentences between 12 months and four years. It can hold up to 664 men. Bridgewater NHS Foundation Trust provides physical health services, while mental healthcare is provided by Greater Manchester West NHS Trust.

HM Inspectorate of Prisons

22. There has been no inspection of Hindley since it became an adult prison. During the last inspection as a YOI, in March 2014, inspectors noted that the number of incidents of self-harm had increased since their last inspection. ACCT procedures had been improved, but flaws in care planning, observation levels and staff entries remained. All the young men were given information about substance misuse during induction, but this was not always effective. Inspectors reported that levels of violence and intimidation remained high, although much had been done to try and address these problems. The inspectors also identified weaknesses in the analysis of data relating to bullying and violence reduction.

Independent Monitoring Board

23. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to 2015, the IMB said that through observation it seemed that the staff and management at Hindley were committed to providing a safe environment for prisoners. The prison had issued guidance to staff on ACCT best practice and use of caremaps. The Board reported that the use of new psychoactive substances had contributed to an increase in violence and reports of bullying. Although the prison had worked hard to reduce drug taking, it was still a major problem.

Previous deaths at HMP Hindley

24. Mr Connell's death was the first self-inflicted death at Hindley since 2012. In the previous investigation, we raised concerns about the lack of systems for identifying and supporting vulnerable prisoners and those who had been targets of bullying. Hindley had implemented our recommendations and this investigation found that the procedures were working effectively.

Assessment, Care in Custody and Teamwork

25. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met.

Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

26. NPS are an increasing problem across the prison estate and can be difficult to detect. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. In July 2015, we published a Learning Lesson Bulletin, which 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 because of the links between NPS and debt and bullying.

Incentives and Earned Privileges Scheme (IEP)

27. Each prison has an incentives and earned privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

28. On 6 January 2015, Mr Stephen Connell was sentenced to eight weeks in prison, for failure to comply with a community order, and taken to HMP Altcourse. He had been in prison before. Mr Connell's Person Escort Record (PER - which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) noted that he had attempted to hang himself in 2008.

29. At his initial health screen, Mr Connell disclosed that he used cannabis daily as well as 'Black Mamba' and 'Spice', new psychoactive substances (NPS). He said he had no current thoughts of suicide or self-harm, and explained that his attempt to hang himself had been due to stress.

30. Mr Connell was due to be released on 2 February 2015, but was remanded for further offences. On 19 February, healthcare staff admitted him to the inpatient unit, as wing staff believed he was under the influence of an illicit substance. He eventually disclosed that had used 'three buckets of Black Mamba'. (This is a method of smoking drugs using a large container, such as a bucket and a smaller bowl or bottle.)

31. On 23 February, Mr Connell threatened to kill himself, as said he felt anxious on his wing and wanted to move. Staff began the ACCT procedures and observed him five times per hour. An ACCT assessment was held the next morning. This was followed by the first case review, chaired by the unit manager and attended by a member of the healthcare team. Mr Connell told them that he regretted what he had said and did not want to die. He had previously asked to be treated as a vulnerable prisoner, but was happy to remain on his current wing until he had been assessed. Staff then closed the ACCT, as Mr Connell said that he had no thoughts of self-harm and was reassured that they would arrange a move.

32. On 23 April, Mr Connell told a nurse that he had thoughts of harming his cellmate. Staff moved him to a single cell as a precaution. At a mental health assessment the next day, Mr Connell said that he had threatened to harm his cellmate as he owed debts around the prison and wanted to move to a single cell. He said that he sometimes heard voices, but would not elaborate on this. The nurse concluded that there were no symptoms of psychosis, and no further clinical action was necessary. Mr Connell later moved back to a shared cell.

33. During an ACCT check on Mr Connell's cellmate on 8 May, staff found Mr Connell with a towel tied around his neck. He said he had tried to hang himself, as he did not get along with his cellmate and wanted to move cells. Staff moved him to another cell overnight and began the ACCT procedures, observing him five times per hour until the following morning. At an ACCT assessment the next day, he said that he had no thoughts of self-harm, it had been a way of 'engineering' a move to another cell, as he knew that two prisoners on ACCT monitoring were not allowed to share a cell. He reiterated the same reasons during the case review that followed and staff closed the ACCT.

34. On 23 July, Mr Connell received a suspended sentence for handling stolen goods and burglary. However, he remained on remand for other offences.

35. On 27 August, Mr Connell was sentenced to 16 weeks in prison for aggravated vehicle taking and was transferred to HMP Forest Bank. A nurse completed a health screen and noted in his medical record that he was fit and well, with no concerns about his physical health, or thoughts of suicide or self-harm. In a separate entry, the nurse noted the information on the PER about his attempt to hang himself.

36. During his induction, Mr Connell explained the circumstances that had led to ACCT monitoring at Altcourse and reiterated that he had no current thoughts of suicide or self-harm.

37. On 11 September, staff supervising prisoners in the exercise yard believed Mr Connell was under the influence of illicit drugs, as he looked unwell and could not stand or speak. They took him to the healthcare centre, where staff assessed and monitored him for several hours until his symptoms subsided. He denied using any drugs.

38. On 17 September, Mr Connell was convicted of burglary and sentenced to 28 months in prison. He then returned to HMP Altcourse and lived on the vulnerable prisoners' wing. The reasons for this were not recorded but, during his previous stay at Altcourse, he had lived on the wing at his own request.

39. On 28 September, Mr Connell became disruptive during an education class. When challenged, he said that he did not want to be located with sex offenders and if he was not moved he would, 'get on the bars'. After a risk assessment on 1 October, staff agreed to move him to a standard residential unit. They warned him of the risk that other prisoners would know he had previously lived on the vulnerable prisoners' wing, but Mr Connell said that he did not know of any current prisoners at Altcourse who had issues with him.

40. Mr Connell moved to another wing on 10 October. He received warnings on 10, 12 and 27 October for poor behaviour and being abusive and threatening towards staff and other prisoners.

41. Mr Connell transferred to HMP Hindley on 30 October. At his health screen, he told a nurse that he had no thoughts of suicide or self-harm and had never tried to harm himself in custody or in the community. Neither she nor the other reception staff referred to the previous threats of self-harm noted on his medical record, or the information on the PER about his attempted hanging in 2008. Mr Connell said that he used cannabis daily and had taken drugs before he left Altcourse that morning.

42. The next day, the nurse carried out a detailed secondary health assessment. She noted no other concerns about Mr Connell's physical or mental health. On 2 November, a healthcare administrator processed a substance misuse initial assessment form, but there is no record of who made the referral.

43. On 4 November, Prisoner A slashed Mr Connell's neck with a sharpened piece of plastic cutlery. The nurse manager treated the wound. That afternoon, Mr Connell's offender supervisor had a meeting with Mr Connell, who told her very little about the assault, but said that it had been related to something that had happened while he was at Altcourse. Prisoner A gave conflicting accounts to

prison staff and the police as to whether the assault had been arbitrary or planned. An internal investigation concluded that it had been a random assault. Prisoner A was later charged with wounding with intent.

44. As a result of this incident, the safer custody team placed Mr Connell on a Support Intervention Plan, which aims to support prisoners identified as vulnerable, but who are not considered at risk of suicide or self-harm. Staff also moved him to a single cell, as he felt more vulnerable after the assault.

45. At a meeting on 18 November, Mr Connell told his offender supervisor that he accepted he would not qualify for Home Detention Curfew, as he had no permanent address, but he wanted to transfer to another prison. She said that she believed Mr Connell's wish to transfer was due to the earlier assault, even though Prisoner A had already transferred from Hindley. She spoke to the department responsible for transfers who added him to the list, but did not consider it urgent.

46. On 3 December, Mr Connell told wing staff that other prisoners had thrown urine under his cell door. Staff checked the CCTV footage of the landing, but did not see anyone doing this and noted there had been minimal activity near Mr Connell's cell door. They recorded on the SIP document that Mr Connell was isolating himself and would not leave his cell. He had also threatened and abused staff when they did not immediately agree to his requests. Staff challenged Mr Connell about his behaviour and told him it was unacceptable.

47. On 4 December, an officer recorded that Mr Connell stayed in his cell, as he was worried that other prisoners would assault him. He shouted abuse at other prisoners through his door, and she felt he did this to contrive a move to another wing. In a police statement, she said that, when he first arrived on E wing Mr Connell was generally polite, but he became frustrated and abusive to staff. They had found it difficult to facilitate showers and meals for a number of prisoners on E wing, such as Mr Connell, who were considered vulnerable, and remained in their cells. She recalled that during the first few weeks of December, Mr Connell had made allegations of bullying, but equally other prisoners had complained that he was abusive towards them.

48. Another prisoner told staff that if Mr Connell's cell was opened he would be 'stabbed up' by other prisoners, as he had called them 'nonces' and wound them up from behind his door. The prisoner also complained that he had spat at him, and he thought Mr Connell's behaviour was due to boredom. He said that he and other prisoners had retaliated with abuse, and it would go back and forth.

49. Just before midnight on 5 December, Mr Connell told a night patrol officer that he was hearing voices. The night patrol officer noted that she intended to refer him to healthcare staff, for a mental health assessment, but there is no record that this was done. During the evening of 6 December, Mr Connell took 12 paracetamol tablets. The National Poisons Unit confirmed that the number of tablets was under the toxic level. Nevertheless, healthcare staff conducted medical observations every four hours during the night and referred him to the mental health team. Staff also started the ACCT, procedures, with three observations per hour. Mr Connell said that he had taken the paracetamol because he was 'depressed and fed up'.

50. At 10.30am on 7 December, an officer conducted an ACCT assessment. Mr Connell named several prisoners who were allegedly bullying him, as they thought that he was a sex offender (which was not the case) and had 'Googled' him on an illicit mobile telephone. He also spoke about his previous self-harm at Altcourse and said that he had tried to hang himself, because of bullying, but staff had intervened. Mr Connell said that he had no current thoughts of self-harm, although this could change if the bullying continued. The officer submitted a report to the security department and informed the Safer Custody team of Mr Connell's reports of bullying.

51. A Supervising Officer (SO) chaired an ACCT case review in the afternoon, with several staff. No healthcare staff were present. Mr Connell's main issues were that other prisoners were bullying him and he did not feel safe. He said that he owed other prisoners 5oz of tobacco as payment for five 'joints' of NPS. He also felt low due to the lack of contact with his family. Staff recorded his level of risk as 'raised' and set his observations at three per hour.

52. The SO recorded the caremap actions, which were that the chaplain should get in touch with Mr Connell's brother, and arrange for contact between them; and subject to a risk assessment, he should move to a shared cell. However, this did not happen as there were no suitable prisoners to share a cell at that time.

53. At interview the chaplain said that Mr Connell appeared to prefer his own company, but she did not think he was 'self-isolating'. His main concern was his debt, which had made him very unpopular. He admitted that he owed a lot of tobacco and that he had taken NPS from other people on the wing. He also missed contact with his family. Mr Connell had given her the name and telephone number of his next of kin, who he had said was his brother. He asked her to tell him that he was in debt and needed money. (She later learned that the man was a friend.)

54. The chaplain telephoned the number given twice that day (and again the following day). As there was no answer, she left a message and a contact number. When she explained to Mr Connell that she had been unable to make contact, he seemed unconcerned and said he would get in touch himself.

55. Late afternoon, a mental health nurse assessed Mr Connell. He told her that the overdose of paracetamol had been an act of self-harm and a cry for help to get support, rather than a suicide attempt. He added that he had previously attempted to hang himself in Altcourse but had alerted staff, as he did not wish to die. He said that if the bullying continued, he would cut himself with a razor, as this would 'get staff to listen to him'. Mr Connell also told the nurse that he had heard voices telling him to do things, but thought this might be due to smoking Spice.

56. The nurse discussed alternatives to harming himself, but Mr Connell said that he had little faith that they would work. She noted that wing staff were aware that he wanted a transfer from Hindley. She concluded that he was struggling because of bullying. She did not consider that he needed mental health input, but referred him to Phoenix Partnership, a non-clinical drug service.

57. Staff reviewed all the prisoners Mr Connell had named as bullying him, in line with Hindley's safeguarding policy. However, there was no evidence to support his claims so they did not initiate any Behavioural Intervention Plans (BIP) for the other prisoners.

58. On 8 December, some prisoners threw water under Mr Connell's cell door. They claimed that this was in retaliation for him being abusive to them the previous evening. Staff moved Mr Connell to a cell on the ground floor, where he could be better observed, but he continued to shout abuse at other prisoners. Staff considered moving him to another wing, but it was not possible at that time.

59. At a safer custody meeting on 10 December, the minutes recorded that a wing representative said Mr Connell had been volatile towards staff and had caused trouble by being abusive to other prisoners. It was decided that while staff were managing him under the ACCT procedures, the SIP would be suspended. The meeting also noted that Mr Connell was one of a number of prisoners believed to be engineering a move back to Altcourse.

60. A SO chaired an ACCT case review the same day, with a member of the chaplaincy team. Mr Connell described his mood as 5 out of 10, and said that being locked in his cell was not helping. The SO explained that staff were limited in what they could offer as he claimed to have problems with so many other prisoners. However, he added to the caremap that he would contact the education department about providing some in-cell work and that his offender supervisor was chasing progress on his transfer. Mr Connell's level of risk and observations remained the same. At interview, the SO said he had spoken informally to a member of the education department about the possibility of in-cell work, but he had not taken any other action.

61. During the night of 10/11 December, a night patrol officer recorded that Mr Connell had 'threatened to ligature' and then laughed about it with another prisoner. When she went to his cell he had threatened to throw urine over her and slit the throat of the first member of staff who opened his door.

62. In view of Mr Connell's threats, a SO chaired an ACCT review on 11 December, with a mental health nurse. Mr Connell's explanation was that he had argued with the night patrol officer and his 'head just wobbled'. He had then tried to ligature with a sock and a piece of bed sheet. The SO decided that the level of risk was unchanged (raised) and observations would remain at three per hour. He also told Mr Connell that, as he had received three negative comments in the past two days, any further negative entries in the next 28 days would result in a downgrade to the basic regime level of the IEP scheme.

63. On 15 December, the offender supervisor noted that due to Mr Connell's continued poor behaviour, staff had found it difficult to get another suitable prison to accept him. She shared this information with the safer custody team.

64. On 16 December, a SO chaired an ACCT review, attended by a mental health nurse. Mr Connell said that things had improved on the wing, and he had resolved his problems with the other prisoners. Despite this, he was still apprehensive about leaving his cell, in case he was assaulted again, but he had

no thoughts of, or intention to self-harm. The SO reduced his risk to low and his observations to hourly.

65. On 21 December, wing staff allowed Mr Connell to help with cleaning the landing. They recorded that he worked well, and had the potential to be employed in the role permanently. Some of the other cleaners on the wing were prisoners that Mr Connell had claimed to be bullying him, but no issues were reported.

66. During the morning, a support worker from the Phoenix Partnership drug service visited Mr Connell. However, he said he was not currently using drugs and declined support from the service.

67. In the afternoon, Mr Connell called a SO to his cell and squirted her with water. When she asked for an explanation, Mr Connell said, 'I do not know'. She placed Mr Connell on disciplinary report and referred him for reduction to the basic regime. When he received the paperwork that evening, he reacted by smashing the observation panel on his cell door.

68. On 22 December, staff downgraded Mr Connell to the basic regime because of his recent poor behaviour. This meant his in-cell TV was removed, he had reduced access to goods from the prison shop, and he was entitled to fewer social visits.

69. The next day, a SO chaired an ACCT review, with a member of the offender management unit and a wing officer. No healthcare staff attended. Mr Connell was positive and said that the issues that had led to the ACCT had been resolved. He was socialising with other prisoners, and was still hoping for a transfer. In view of his improved outlook and no further issues or attempts to self-harm, the SO considered his risk was still low and closed the ACCT. Only one of the caremap actions had been signed as completed.

70. On 29 December, staff raised Mr Connell to the standard level of the IEP scheme. At an ACCT post-closure review the next day he reiterated that his issues had been resolved. He said that he had friends for support and would ask staff if he needed help.

71. Despite a seemingly positive change in Mr Connell's behaviour, a few days later he was verbally abusive and smashed his observation panel, as staff would not let him out of his cell to empty a waste bin.

72. On 6 January 2016, Mr Connell threw hot water over an officer, ran back to his cell and prevented staff from entering. He was ordered to leave his cell and, as he did so, he lunged at staff. They restrained him and took him to the segregation unit. Two days later, he was moved to F wing and placed on the basic level of IEP for 28 days. Mr Connell settled well in F wing. He worked in the contract workshop and engaged with support to address his offending behaviour.

73. On 29 January, a workshop officer recorded that Mr Connell had received numerous verbal warnings for poor behaviour, including throwing around items in the workshop. At a safer regimes meeting that day, a SO noted that the safer custody team had not restarted Mr Connell's SIP after his ACCT monitoring had

ended in December and they had not actioned a safeguards referral that said Mr Connell might still be self-isolating.

74. The SO explained to the investigator that there was no defined timescale for a SIP, it was tailored to each prisoner. The safer custody team would discuss the prisoner weekly to ensure the SIP was meeting their needs and whether the issues identified on the SIP had been resolved by the intervention plan. Wing staff told him that Mr Connell had been collecting his own meals, using the shower, interacting with other prisoners and attending work. In view of this, she considered a SIP was not required at that time.

75. During routine cell checks on 1 February, staff discovered two broken broom handles behind Mr Connell's bed and warned him that this was unacceptable.

76. Mr Connell had worked regularly after his move to F wing but on 3 February, he refused to attend. His time on basic regime was due to end on 4 February. However, due to his refusal to attend work and other negative entries about his behaviour, staff extended it for a further seven days.

77. On 6 February, Mr Connell's personal officer reminded Mr Connell that if his behaviour did not improve, he would remain on the basic regime. Despite warnings, Mr Connell still refused to go to work.

78. On 10 February, an officer found a TV hidden in Mr Connell's cell. When the officer removed it, Mr Connell was verbally abusive. The same day, Mr Connell asked his offender supervisor about the progress of his transfer. She agreed to check, but explained that in view of his persistent poor behaviour, a transfer was unlikely.

79. Mr Connell had completed a complaint form, which he had submitted on 10 February. In the complaint, Mr Connell stated that he had been bullied, and had stopped going to work as another (unnamed) prisoner had hit him and that he had placed himself on voluntary 'bang-up'. He felt that in view of this, he should not receive warnings for refusing to attend work. Mr Connell also said that he had recently heard voices telling him to do bad things, and that being in his cell all day did not help. Again, in the complaint he asked for his TV to be returned.

80. The personal officer told the investigator that the complaint form had been passed to him and he had placed it in his tray, with the intention of having a conversation with Mr Connell to discuss the points that he had raised. The officer explained that he has ten days to respond to complaints by prisoners, and had not responded prior to the events on 18 February.

81. On 15 February, Mr Connell told an officer, that he felt unsafe on his wing and elsewhere in the prison. She asked him to write down the names of prisoners with whom he had problems. Mr Connell named nine prisoners and said they thought he was a sex offender. She submitted an intelligence report and a safeguards form, noting her conversation with Mr Connell. At interview, she told the investigator that she had checked with another officer that her actions were correct. They recognised very few of the names. Of the three prisoners located on F wing, only one had previously been involved in bullying. That prisoner lived on the opposite side of the wing to Mr Connell, so they would have had no direct

contact.

82. The personal officer recorded on 17 February that Mr Connell had become increasingly challenging over recent days and had persistently demanded a television, although he was aware that he was not entitled one.

83. On the same day, Mr Connell asked an officer if she could help him to get off the basic regime, as staff now knew the reasons why he refused to work. She replied that she had contacted the safer custody team, who had assured her that they would discuss him at the next meeting, scheduled for the following Friday. She asked the safer custody team whether they could remove the requirement for him to work, for safeguarding reasons, as this would help to prevent further negative comments and increase his chance of being placed on the standard regime the following week. They advised her to raise it at the safer custody meeting. She reported back to Mr Connell and thought he seemed happy with this outcome.

84. Early on the morning of 18 February, Mr Connell pressed his cell call bell and asked an officer about his IEP review. After speaking to a colleague, the officer told Mr Connell that the wing's custodial manager intended to update him in the afternoon about his activities and safeguarding.

85. At 9.12am, a SO noticed that Mr Connell's IEP status was due to be reviewed that day and that he had received four negative entries for refusing education. He told the wing staff that he would speak to Mr Connell later. The SO explained to the investigator that, if prisoners refused to attend education, they had to be placed on the basic regime.

86. At approximately 10.00am, while the SO was on his way to F wing, Mr Connell shouted to him from a window that a review of his basic status was due that day and he could not attend education, as other prisoners were after him. The SO told him that due to his negative entries, he would have to remain on the basic regime and advised him to speak to wing staff about the possibility of removing him from the education list for safeguarding reasons. Mr Connell told him that an officer was already aware of this, therefore the SO agreed to look into it further and speak to Mr Connell later. Mr Connell then threatened to vandalise his cell. Shortly afterwards, the SO telephoned the officer to discuss Mr Connell.

87. At around 11.40am, an officer and a prisoner were delivering lunch packs to prisoners. The officer said that when he reached Mr Connell's cell it appeared empty, so he placed the lunch pack on his bed. He then noticed a duvet cover hanging over the window. He pulled it back and discovered Mr Connell suspended from the bars of the cell window. He immediately cut the ligature and placed Mr Connell on the floor. As he did not have a radio, he called out to colleagues for help and began cardiopulmonary resuscitation (CPR).

88. An officer radioed a code blue at 11.43am. (A code blue is a medical emergency code, which indicates to staff that a prisoner is having breathing difficulties or unconscious.) The control room called an ambulance at 11.44am. Several other staff responded to the code blue and assisted with CPR until nurses arrived.

89. Two nurses and a Healthcare Assistant went to the cell. A nurse found Mr Connell unresponsive, with no movement of the abdomen and no respiratory effort. A defibrillator advised no shock, and they continued CPR. Shortly afterwards, an output was detected. Paramedics arrived at 11.56am. After further treatment, the paramedics took Mr Connell to hospital, where he was admitted to the intensive care unit. Two officers escorted him, without using restraints.

90. Later that day, a prisoner who had lived in the cell next to Mr Connell's since 12 February told wing staff that Mr Connell had been a victim of bullying in the past few weeks. He refused to give the names of those involved, as he did not want to be a 'grass,' and said that Mr Connell had not reported this for the same reason. This prisoner and another prisoner also told them that Mr Connell had said he intended to use a ligature, so that staff would take him off the basic regime.

91. On 19 February, after the hospital confirmed Mr Connell's condition was serious, the prison released Mr Connell on temporary licence on compassionate grounds. One prison officer remained at the hospital to support his family and liaise with hospital staff.

92. Mr Connell did not regain consciousness. He remained at hospital and died in the early hours of 20 February 2016.

Contact with Mr Connell's family

93. A prison manager was appointed as the prison's family liaison officer. He went to the hospital on 18 February, where he met the friend Mr Connell had nominated as his next of kin, Mr Connell's sister and some of his friends. The next day, he spoke to Mr Connell's stepmother, who said his father was content for his friend to remain as his next of kin.

94. At 8.15am on 20 February, the prison manager and the Governor of Hindley visited Mr Connell's parents. They offered condolences and support. Over the next few days, the manager kept in touch with members of Mr Connell's family and arranged for Mr Connell's friend and his parents to visit Hindley. The prison contributed to the funeral costs, in line with national policy.

Support for prisoners and staff

95. After Mr Connell was taken to hospital on 18 February, the duty governor that day debriefed the staff involved in the emergency. He offered his support and that of the staff care team. After Mr Connell's death, a prison manager contacted the escort officer to offer support.

96. The prison posted notices informing other prisoners of Mr Connell's death on 20 February, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm prevention in case they had been adversely affected by Mr Connell's death.

Information from prisoners

97. In a statement, the prisoner in the cell next door said that he and Mr Connell had talked through the cell water pipes at night. Mr Connell had told him that he stayed in his cell as he was in debt. He missed his family and found it difficult on the basic regime. He had only seen him out of his cell once and knew that he did not socialise with other prisoners. He thought that Mr Connell's actions might have been an attempt to manipulate staff. He subsequently retracted some of his comments and said that he had never witnessed any issues between Mr Connell and staff or other prisoners.

98. Another prisoner said he had known Mr Connell from their previous wing. He told the police that Mr Connell owed him £50 and was in debt to several other prisoners. He said that on either 16 or 17 February, during a conversation through his cell door, Mr Connell had said, 'I am going to string myself up'. When he asked why, he had replied, 'The staff are taking the piss out of me', and he intended to self-harm as a way of getting a TV, or a move to another wing. He had shown the prisoner a piece of torn bedding tied to his window and another piece hidden under his mattress. The prisoner said that he had told a female officer (unnamed) about Mr Connell's threats to harm himself, but he did not mention the torn bedding.

Post-mortem report

99. The Coroner has confirmed that the cause of death was hanging. Toxicology tests, including those for new psychoactive substances, indicated that Mr Connell had not taken any illicit drugs just before his death.

Findings

Assessment of Mr Connell's risk of suicide and self-harm in reception

100. Prison Service Instruction (PSI) 07/2015, about early days in custody, requires reception staff to be alert to the increased risk of suicide and self-harm among new prisoners. Staff should examine the prisoner's PER, and any other relevant documents to identify any immediate needs and recorded risks. Mr Connell's PER showed that he had previously attempted suicide in 2008, and his medical record also contained clear entries about previous threats of self-harm. As reception staff in October 2015 recorded that he had never self-harmed, in custody or in the community, they had evidently not read or taken account of the available information. Therefore, we do not consider that the prison complied with this instruction. We make the following recommendation:

    The Governor should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm. When they decide not to begin ACCT procedures for prisoners with significant risk factors, or who arrive with suicide and self-harm warning forms, PER information they should clearly record the reasons.

Assessment, care in custody and teamwork (ACCT)

101. Mr Connell was monitored under the ACCT suicide and self-harm prevention procedures between 6 December and 23 December 2015. PSI 64/2011 requires ACCT case reviews to be multidisciplinary, where possible, involving staff from relevant departments and services. It is mandatory for a member of healthcare staff to attend the initial case review, but this did not happen in Mr Connell's initial review. The other four case reviews were multidisciplinary and mental health staff attended two.

102. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. Caremaps should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact, and access to diversionary activities. Each action on the caremap must be tailored to meet the individual needs of the prisoner, should aim to reduce risk, and should be time bound.

103. Addressing the lack of contact with his family was an action that staff had listed on Mr Connell's caremap. The chaplain had attempted to follow this up. Moving into a shared cell was another action, but lack of space and Mr Connell's own behaviour prevented such a move. There is no evidence that the caremap was updated at subsequent ACCT reviews and only one of the six actions on the caremap had been signed off as completed when staff closed the ACCT. 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 guidance, including:

- **A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.**
- **Setting effective caremap objectives, which are specific and meaningful, aimed at reducing risk; ensuring that staff update caremaps during reviews; and that ACCTs are not closed before all caremap actions have been completed.**

104. Mr Connell's next of kin said they had seen cuts on Mr Connell's arms when he was in hospital. The post-mortem report notes a number of 'superficial, healing wounds, consistent with self-injury'. Prison staff had not noticed these injuries and Mr Connell had not told them that he had recently self-harmed. It is possible that long sleeved clothing had covered the cuts.

Violence reduction and bullying

105. In a previous investigation at Hindley, in 2012, we raised concerns about deficiencies in the procedures for addressing potential bullying and we made a recommendation for more effective monitoring and supervision procedures. The prison had accepted the recommendation and indicated that it had:

- Reviewed and revised the Safeguards referral process, and issued new guidance.
- Introduced a daily, multidisciplinary, Safeguards "tasking" meeting to discuss recently submitted Safeguards reports and agree appropriate actions.
- Developed Support Intervention Plans (SIP) to monitor arrangements and evidence the supervision of young people identified as vulnerable, which were reviewed at a weekly multidisciplinary Safer Regimes meeting.

106. Mr Connell had said that he was in debt to other prisoners for tobacco and NPS and was concerned for his safety. The investigation did not find any evidence that other prisoners were deliberately targeting Mr Connell. It was well documented that he had been verbally abusive and threatening towards other prisoners, but these had usually been two-way arguments with verbal abuse exchanged by both sides.

107. The investigator looked into the background of the prisoners Mr Connell named, and found no evidence of previous involvement in bullying. Some were not located on the same wing and others were not known by staff. The prison had investigated the claims made by Mr Connell, but no prisoners were placed on Behaviour Intervention Plans as a result. The police also interviewed several prisoners and staff. No one had witnessed any prisoners bullying Mr Connell.

108. Staff had placed Mr Connell on a SIP after the assault in November. After he said that he would not go to work as he was under threat, staff appropriately submitted Safeguards reports and discussed him at Safer Regimes meetings. However, the prison did not review Mr Connell's suspended SIP when the ACCT was closed in December and staff only became aware of this in late January. This is unfortunate,

and the prison needs to ensure that they review suspended SIPs at the earliest opportunity, in such circumstances. In spite of this, we are satisfied that well managed safeguarding procedures were in place at Hindley and staff were aware of their responsibilities in protecting vulnerable prisoners. We therefore make no recommendation on this issue.

New psychoactive substances

109. We are concerned about the prevalence of NPS in prisons and the effect it has on the behaviours and health of prisoners. In July 2015, we published a learning lessons bulletin about deaths in which NPS was thought to be a factor. We highlighted several lessons to be learned, including giving staff information about NPS to help them identify when prisoners are using it and having an effective drug supply reduction and violence reduction strategy.

110. Hindley has such a strategy. It includes providing information to all new prisoners, during induction, about the negative health effects, and the sanctions that will apply to those suspected of its use. The substance misuse team also provides literature to prisoners and posters are displayed on the wings in an effort to educate prisoners. After the sale and possession of NPS became a criminal offence in May 2016, Hindley issued additional guidance to staff, explaining the process for dealing with prisoners found in possession of such substances.

111. Mr Connell admitted using 'Spice' and 'Black Mamba', new psychoactive substances, at Hindley. One of the side effects of NPS is increased paranoia, which Mr Connell had displayed. Another issue linked to the use of NPS among prisoners is debt. By his own admission and from information provided by other prisoners, Mr Connell was in debt. He gave this as one of the reasons he was concerned for his safety.

112. Although toxicology tests found no traces of NPS, we know that due to their continually changing nature and the number of variants, it is not possible to exclude this completely. We are satisfied that staff appropriately referred Mr Connell to a drug service, although he declined their help, and that the Governor has taken appropriate steps to address the problem of NPS. We therefore make no recommendation on this issue.

Clinical care

113. The clinical reviewer noted that healthcare staff did not diagnose any mental health problems, except for Mr Connell feeling low about his circumstances. She concluded that they had responded appropriately to his presentation and that his healthcare, mental healthcare and the emergency response was the equivalent to that which he could have expected in the community.

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