



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at HMP Highpoint in January 2014**

Our Vision

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

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Highpoint on 9 January 2014. He was 23 years old. I offer my condolences to the man's family and friends.

An investigator was appointed and a clinical reviewer reviewed the man's clinical care. HMP Highpoint co-operated fully with our enquires.

The man had spent over five years in prison at the time of his death. At HMP Blundeston, he developed a positive therapeutic relationship with a mental health nurse and his self-harm decreased. Due to the imminent closure of Blundeston, the man moved to HMP Norwich. Three days later, he harmed himself and was monitored under suicide and self-harm prevention procedures. After nine days at Norwich he transferred to HMP Highpoint on 18 December. The nurse who conducted his reception health screen was concerned about the man's risk of self-harm and referred him urgently to the mental health team. The mental health nurse who assessed him decided that further intervention was unnecessary.

The man was unsettled initially but began to develop a positive rapport with a few officers on the induction unit. For much of his time at Highpoint, he was managed under suicide prevention procedures, but mental health staff were not included in his case reviews and the full range of his risk factors and information known about him do not appear to have been fully considered when taking decisions about his care. The man had a lengthy discussion with a prison chaplain two days before he died which could have been an indication that he was in crisis and needed increased support, but this opportunity was missed. On the evening of 9 January, a patrol officer found the man hanging in his cell.

The emergency response was initially delayed as the officer who found him did not use an emergency code. Many of those involved in the emergency were unaware where essential emergency equipment was kept and, because of an incident on another unit, there was a long delay of around 15 minutes before trained staff and medical help became available.

The clinical review found that the man's mental health care was weak and fell below that he could have expected in the community. I am concerned that in the second investigation within a year, some weaknesses in mental health services at Highpoint have been identified. Improvements are also required in the management of the suicide and self-harm prevention procedures and the response to emergency incidents.

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

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SUMMARY

1. The man was remanded into custody in November 2008, charged with arson with intent to endanger life. He was 18 at the time. He was convicted in March 2009 and received an indeterminate sentence for public protection, with a minimum period to serve of two years and two months before he could be considered for release. While at Aylesbury, the man began to harm himself by cutting and he was managed under suicide and self-harm prevention procedures known as ACCT. The mental health team assessed him and they discussed his childhood diagnosis of attention deficit hyperactive disorder. He explained that he used self-harm as a coping mechanism and to get attention but had never felt suicidal.
2. The man transferred from HMP/YOI Aylesbury to HMP Blundeston in March 2012. He was relatively settled at Blundeston but moved to Norwich on 9 December. Three days later, after a suspected overdose, staff opened an ACCT and on 18 December, the man transferred to Highpoint. Early on the morning he moved, he had cut himself but after a case review the next day, staff at Highpoint closed the suicide and self-harm procedures. An ACCT was reopened that evening, when the man harmed himself again, but was closed again the next day.
3. The man had had a positive relationship with a mental health in-reach nurse at Blundeston and found it difficult to start again with a new worker. He indicated that he did not want to be managed by the in-reach team at Highpoint and the psychiatric nurse who assessed him did not discuss his case with the mental health team, and he was not taken onto their caseload. This was not in line with expected practice. The man felt anxious about finding staff at Highpoint he could trust, but he began to open up to one or two officers.
4. After a further act of self-harm on 23 December, ACCT procedures were opened, which continued until his death. Entries in the ACCT document were mostly observational rather than indicating meaningful interaction. The man had a long discussion with one of the prison chaplains two days before his death. He told him about the death of a close friend some time ago and the recent deaths of two others and his guilt about being the only person left from their group. The chaplain did not note this conversation in the ACCT documents or consider whether the man needed increased support.
5. At a case review on 9 January 2014, the man said he was feeling more settled at Highpoint and trusted some of the staff. However, he did not think he could talk openly to those he did not yet trust.
6. At 8.33pm that evening, a patrol officer found the man hanging from his upturned bed. He radioed for urgent help, but did not use an emergency code blue as he should have done. The prison's designated response officers were with an ambulance technician dealing with another incident in the prison and none of them responded. The patrol officer went into the man's cell on his own and supported the man's body. After a minute or two, he called a code

blue emergency, and asked if staff were on their way. Another officer arrived after a few minutes and they attempted to resuscitate the man. Both officers continued their efforts for a further seven or eight minutes before another member of staff and the paramedic reached the cell. At 9.34pm, a doctor from an air ambulance decided to stop the resuscitation attempts and declared the man dead.

7. Unfortunately, an officer did not see a long letter the man had written her detailing significant events in his life and his current thoughts until after his death. Had she read it earlier, it might have led to an increase in monitoring and support.
8. We are concerned that although the reception nurse at Highpoint assessed the man as at risk of self-harm, the officers closed the ACCT procedures the day after he arrived without appropriate consultation. When the ACCT was reopened after the man self-harmed again the management of the process was poor; staff did not include the mental health team in case reviews, documents were incomplete and staff gave little consideration to new information which might have impacted on the man's risk. When the man transferred to Highpoint, his referral to the mental health team was not considered in line with the normal pathways of care. His mental health needs were not therefore fully considered and he did not see a GP for a review of his health and medication.
9. The emergency response was poor and led to a significant delay in attempting resuscitation. The officer who found the man hanging commendably went into his cell and coped with the incident on his own at first but back-up took too long. We make four recommendations about these matters.

THE INVESTIGATION PROCESS

10. The investigator issued notices to staff and prisoners at Highpoint informing them of the investigation and invited anyone with relevant information to contact her. No one responded.
11. The investigator went to Highpoint on 16 January. She visited the induction unit where the man had lived and collected documents relating to his time in prison. She later interviewed staff and prisoners at Highpoint and gave the Governor feedback on the preliminary findings of the investigation.
12. NHS England, East Anglia Area Team, commissioned a clinical review of the man's clinical care at the prison. The clinical reviewer and the investigator jointly interviewed the healthcare staff.
13. We informed HM Coroner for Suffolk of this investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. They did not have any specific issues for the investigation to consider.
15. The man's family received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly. The man's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP HIGHPOINT

16. HMP Highpoint, in Suffolk, is on two sites, Highpoint South, which was the original HMP Highpoint, and Highpoint North, which was previously known as HMP Edmunds Hill. Highpoint holds up to 1,323 category C sentenced men. (Category C prisoners are those who are not judged ready for open conditions but who are unlikely to escape and do not require high security.)
17. Care UK provides healthcare services at the prison. There is a purpose-built healthcare centre but no inpatient facility. Mental health services are provided by the Norfolk and Suffolk Mental Health NHS Foundation Trust.

HM Inspectorate of Prisons

18. The last inspection of Highpoint was in September 2012. The inspectorate found that, while there were some problems, the prison largely provided a decent and safe environment.
19. Inspectors noted that the level of self-harm and number of prisoners subject to ACCT suicide and self-harm prevention procedures was similar to other category C prisons. The quality of individual care plans was generally good but written observations in ACCT documents were inadequate.
20. Inspectors found that the mental health services were adequate and patients felt supported. However, they recommended improved access to a range of support, including counselling and group therapies. Inspectors considered that because of the large geographical site and lack of overnight healthcare provision, the number of defibrillators was insufficient.

Independent Monitoring Board

21. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community to help ensure prisoners are treated fairly and decently. In its most recently published annual report for 2012, the Board commended staff for their commitment in running a safe and decent establishment.
22. The Board was concerned about the lack of a counselling service for prisoners with psychological disorders. However, they commended the case management procedure for complex cases where prisoners subject to the suicide and self-harm procedures required intervention from multiple agencies.

Previous deaths at Highpoint

23. There were four other deaths at Highpoint in the year before the man's death. The investigations identified some concerns about health services at Highpoint, including the lack of cover when mental health staff were not on duty and that the in-reach team relied on the prisoners' account of their own

mental health needs to determine if they needed support. We have similar concerns about the mental healthcare provided to the man.

Assessment, Care in Custody and Teamwork (ACCT)

24. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable 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. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

25. The man was remanded into custody at HMP/YOI Norwich, when he was 18 years old on 28 November 2008, charged with arson with intent to endanger life. On 24 March 2009, he was convicted and given an indeterminate sentence for public protection, with a minimum period to serve of two years two months. The man had been in the fire cadets when he was younger and had previously been convicted of arson. This was not his first time in prison.
26. The man moved from Norwich to HMP/YOI Aylesbury on 23 July 2009. Towards the end of 2011, he began to self-harm by cutting his arms. He told a mental health worker who assessed him on 16 January 2012, that he had been treated for attention deficit hyperactivity disorder (ADHD) since the age of six but had stopped taking the prescribed medication when he was 17. The man felt the medication had made him feel better and he wanted to re-start it. He said he was generally all right during the day when he was busy working on the wing but it was more difficult at night when he frequently self-harmed. He said that he also got into trouble with wing staff when his mood was too high. The nurse referred him for a medication review.
27. A psychiatrist assessed the man on 23 January and noted he had felt low over Christmas and was still being managed under ACCT procedures after repeated minor cuts to both his forearms. The man told him that he self-harmed to cope and to get attention, but he never felt suicidal. He found it difficult to concentrate and said that he constantly moved around. He said he had an obsession with fire but was no longer a risk and was seeing a forensic psychologist about his offending. The psychiatrist prescribed atomoxetine for ADHD.
28. A month later, the psychiatrist noted that the man felt better in the mornings but said the effects of the medication wore off after lunch and he was unable to keep still. His self-harm had reduced from daily to a couple of times a week. The psychiatrist increased his dose of medication. At the next review in March, the psychiatrist reported that the man no longer had “ups and downs” and was much more able to concentrate, although he cut his arm in order to be managed under the ACCT process as he liked having staff support. The man was due to transfer to a prison for adults and the psychiatrist noted in a handover note that the man used self-harm to manage his feelings and get staff attention, but denied ever intending to endanger his life. The psychiatrist considered that he would benefit from learning to manage without being supported under ACCT procedures.
29. On 27 March 2012, the man transferred to HMP Blundeston, where the prison GP continued to prescribe atomoxetine.
30. In November 2012, the man was referred to the mental health in-reach team to discuss his diagnosis and medication. On 21 November, he told a mental health nurse that he thought he had not benefitted from his medication and felt he was bipolar - with periods of extreme highs followed by lows. During

his low moods, he tended to self-harm. He had cut his arm on 20 November and an ACCT was opened for two days.

31. On 22 November, a doctor at Northgate Hospital noted that the man did not want to continue taking atomoxetine as he felt it had not helped him. The doctor prescribed olanzapine which is used to treat bipolar disorder. The man was not allowed to keep his medication in his cell and this caused a problem with him taking the olanzapine at an appropriate time. He was supposed to take it at night, but as the nurses finished work at 5.00pm, they gave it to him at 4.30pm which made him very drowsy in the evening. In December, his medication was changed to depixol injections, a slow acting drug that lasts for a few weeks.
32. The in-reach team next reviewed the man at the end of December 2012. He told them that since he had stopped taking atomoxetine he found it harder to stay focused, became easily bored and felt a delayed response when speaking. He said that he was only getting four to five hours sleep a night because he could not "switch off". The psychiatrist stopped the depixol in January 2013 because of the side effects and prescribed risperidone (another drug used to treat bipolar disorder). The man did not comply with the prescribed dosage and was told that if he did not take the medication as prescribed, he would no longer be managed by the in-reach team. He then began taking his risperidone regularly.
33. On 20 February, a mental health nurse noted that the man felt stable on his current medication and there had been no side effects. The mental health nurse felt the man was more settled when he had less input from the in-reach team and he told her that he played up when he got more attention. She therefore decided to reduce her contact to monthly meetings.
34. On 21 March 2013, the man collapsed on the wing and was unresponsive. A code blue emergency was called. (A code blue usually indicates a prisoner who has difficulty breathing or is unconscious.) Staff suspected that he had taken an illicit substance and he was taken to the James Paget University Hospital in Gorleston. After he returned to the prison, the man admitted that he had smoked 'spice' (a synthetic drug similar to cannabis). As a result, he lost his job on the servery. Three days later, on 24 March, he made several deliberate cuts to his arm and his foot. An ACCT plan was opened, which was closed two days later.
35. The mental health nurse reviewed the man on 1 May 2013 when he seemed to be low in mood and reported getting little sleep. The man said he felt he had let his family down, particularly his father. He said he did not like himself and this was the reason he self-harmed. He also reported frequent headaches and the mental health nurse advised him to see the GP and the optician. On 16 May, the man told the mental health nurse and the psychiatrist that he had thoughts of suicide and had written plans in his cell. Certain music made him feel suicidal because it reminded him of particular times in his life. He was prescribed an anti-depressant, sertraline and an

increase in his risperidone. Over the next few months, the man continued to take sertraline but the risperidone was stopped.

36. The closure of Blundeston was announced in September 2013. The man had an oral parole hearing due in October, but no date had been set. At a mental health review in mid-October, the man said he was struggling with his mood and felt manic and hyperactive. He talked about a family visit which he felt had not gone well and that he felt like the black sheep of the family. He was prescribed zopiclone to help him sleep but told the mental health nurse it made him feel, knocked out. His current concerns were family issues, his forthcoming transfer to another prison, his parole review, low mood and his fear about how he might cope when he was eventually released from prison. The man said he was not self-harming and had no thoughts of suicide.
37. The GP increased the man's dose of sertraline and, a few weeks later, the mental health nurse noted it had had some positive effect. His concerns about his family continued, but his mood was more stable and his sleep improved. His family visited him frequently at Blundeston, usually a few times each month. Their last visit was on 16 November. After he moved to Highpoint, visits were more difficult.
38. Staff managed the man under the ACCT procedures between 24 and 27 November after he cut his arm. He told the mental health nurse that he no longer had thoughts of self-harm or suicide and that the trigger for his self-harm had been a family issue about his father. He said he was hoping to transfer to HMP Norwich and knew that the majority of staff from Blundeston were moving there.
39. The man transferred to HMP Norwich on 9 December. At his reception screen he denied any current or past suicidal thoughts but said that his mood was poor because he had just been moved to a new prison. The GP continued his prescription of sertraline. A cell sharing risk assessment indicated that he remained a high risk and that he should not share a cell because of his history of arson.
40. On 12 December, the man pressed his cell bell and said he had taken an overdose. Staff found numerous empty medication packages including paracetamol, ibuprofen, senna and antihistamine. They opened an ACCT and sent the man to the accident & emergency department at Norfolk & Norwich University Hospital. No medication was detected in his blood sample and he was discharged early the next morning. After assessing the man, the mental health team recorded that he was frustrated about being moved from Blundeston to Norwich and he felt stressed at being surrounded by short term prisoners. The ACCT assessor noted that he needed support from the mental health in-reach team and to move to a category C prison so he could settle there before his parole hearing scheduled for early 2014. The caremap objectives were to get mental health support, make an appointment for a medication review and to see a drug worker. The man's risk was assessed as low.

41. Just after midnight on 18 December, a nurse examined the man, who had made superficial cuts to his back. He said that he was just fed up of being in prison. He handed in his razor blades and staff checked him hourly through the night. The man transferred to HMP Highpoint later that day, arriving at 1.15pm. He remained on an open ACCT.
42. During the reception health screen at Highpoint, a nurse noted the man's recent self-harm and that he had been receiving support from mental health services since the age of nine. She was very concerned that he was at high risk of further self-harm, so she referred him for an urgent mental health assessment.
43. A community psychiatric nurse (CPN), reviewed the man later that afternoon. She noted his self-harm and that he was being managed under the ACCT procedures and that he had transferred twice recently. She recorded her impression that he was a young man with complex emotional problems. She concluded he did not have a common mental illness, or severe and enduring mental illness but noted his previous psychological support and felt this might help with his management at Highpoint. As the man said his recent deterioration had been triggered by instability caused by his move, The community psychiatric nurse recorded in the ACCT record that he should continue to be supported under the ACCT procedures until he felt more settled. The GP continued the man's prescription of sertraline but did not see him in person.
44. The man went to the induction wing, unit four, where two Supervising Officers (SO) held an ACCT case review at 12.20pm on 19 December. The man told them he did not want to be at Highpoint and would prefer to be at Norwich or Wayland. He said he had no thoughts of suicide or self-harm and had previously harmed himself in order to relieve pressures. He said he did not currently feel under pressure and was going to give Highpoint a chance. The senior officers closed the ACCT as they considered he was no longer at risk.
45. At 7.20pm that night, one of the SOs and an officer re-opened the ACCT because the man had handed in some razor blades and pills and said he felt like harming himself. Staff checked him hourly through the night and two senior officers held another case review the next morning. The man explained that he had found it unsettling to be moved from Blundeston but thought he would be okay once he settled at Highpoint. He mentioned that he had healthcare and mental health appointments that afternoon. (However, his medical record shows that he had only received his sertraline prescription.) For the second time in two days, the staff at the case review closed the ACCT. Neither of the ACCT reviews referred to the community psychiatric nurse's advice that he should continue to be supported under ACCT procedures until he was settled at Highpoint.
46. After a review on 23 December, the community psychiatric nurse noted that the man was no longer being managed under the ACCT procedures. He said that he did not feel the need for a mental health service at that time and agreed not to be taken on to the mental health team caseload.

47. Later that evening, the man told staff he had swallowed some batteries and had cut his arm. An ACCT was opened at 8.25pm. The next morning, the Supervising Officer discussed the reasons for his self-harm. The man said he had not yet settled at Highpoint and had swallowed the batteries because he was bored. He did not want to be dead because it was Christmas time and he was also waiting for the outcome of his parole hearing. The man's caremap had three objectives – to contact healthcare about the swallowed batteries; to relieve the man's boredom with employment; and for him to communicate better with staff to break down barriers. His risk of further self-harm was assessed as low and observations were set at three a day, morning, afternoon and evening.
48. The first case review was held at 2.30pm on 24 December and staff recorded that he did not want to see anyone from the in-reach team. The man said he was not suicidal and would not self-harm again. His anxiety after transferring prisons was beginning to ease and he wanted to get a job on the wing. On Christmas Day and Boxing Day the man seemed more settled, chatted to other prisoners and went to the exercise yard. He had spoken to his family on Christmas Day but after that, had no more credit on his telephone account.
49. An officer noted in the ACCT document on 28 December, that the man had told her he had not slept well and had had a bad day. He had used a coping mechanism of flicking an elastic band to help with his thoughts of self-harm and he had taken a big step by talking to staff about how he felt.
50. To relieve his boredom, the officer suggested the man make a word search to encourage him to do something other than hurt himself. On 30 December, the man gave her two word searches. One of them was about life in prison but the other contained words describing the officer. Many of the words were appropriate, such as 'helpful' and 'listens' but some were over-familiar such as 'lovely', 'cute' and 'attractive'. The officer spoke to her senior officer and wrote a security information report about the incident. She told the investigator she did not feel threatened, just a little uncomfortable, because the words used crossed the usual boundaries between officers and prisoners. The officer told the man that some of the words were inappropriate. She said he tried to laugh it away, but she felt he knew he should not have written them.
51. At 2.15pm on 2 January, the man went to the wing office with a noose tied around the neck of a toy bear and told the officer that it would be him tonight. He had done this several times before and she thought it was a way of getting officers to speak to him and check on him more. She later went to speak to him in his cell and removed his razors. When she asked if there was anything else she should take, the man gave her a newspaper with dried blood on which he said was his. The officer spoke to her senior officer who was concerned that every time she was on duty, the man wanted to speak to her. She was advised to withdraw a little and let other staff help manage the man.

52. A Supervising Officer held an ACCT case review at 3.20pm on 2 January, attended by a probation officer and the prison chaplain. The probation officer could not remember the details of the discussion but said that the man had appeared to be very detached and seemed not to care whether he lived or died. They discussed the man's self-harm the day before (although there is no record of any self-harm in the ACCT document or medical record). He said he had cut his arm because he liked the sight of blood but had no current thoughts of self-harm and he intended to apply for a cleaning job. The ACCT remained open with no change in the staff observation levels and the next review date was set for 9 January.
53. The next day, the probation officer telephoned the mental health in-reach team about the man. A community psychiatric nurse, told him the man did not want to engage with them at that time but he could refer him again if his self-harming behaviour escalated.
54. The man asked to speak to a chaplain on 7 January and the chaplain saw him at around 10.30am in a chaplaincy office. The chaplain had not met him before. The man told the chaplain he had a number of things on his mind. The main thing was that he had recently heard that a couple of his friends had died. One of them appeared to have taken his own life but he was not sure how the other one had died. He told the chaplain that he was also concerned about his grandfathers who were both unwell.
55. The man told the chaplain that, in his early teens, he and a friend had taken some LSD. While they were under the influence, his friend had cut himself and died. He said that he had been able to see what was happening, but because of the influence of the drugs he had been unable to do anything to help. It had been on his mind for a long time. The friends who had just died had sold the LSD to them. The chaplain said this had raised warning bells in his mind and they spoke about the man's feelings of shock and guilt as he was the only one of the group of four friends still alive.
56. The man told the chaplain he had felt quite settled in Blundeston. He said that he had become a bit unsettled as a result of the moves to Norwich and then Highpoint, but there were a couple of female officers that he talked to on the wing.
57. At interview, the chaplain said he could not remember for certain whether he had asked the man about thoughts of ending his life, but believed he had. The man had talked about being a prolific self-harmer in the past. The chaplain's impression was that the self-harm was something he had grown out of and he now chose to deal with issues by talking to the staff and looking for help. He said they spoke for between 40 minutes and an hour and he felt the man was brighter at the end of their discussion. He had been concerned about him but did not think he was at immediate risk of harming himself and was aware he was being managed under the ACCT procedures. After their discussion, the chaplain did not tell anyone else about it and did not record anything about their meeting in the ACCT document. He agreed that he should have done so, although said he would not have recorded the details of

their conversation as he believed that the man had wanted to speak to him in confidence.

58. An officer and Supervising Officer held an ACCT case review at around 11.00am on 9 January. There were no other members of staff present. The SO said he had tried on a couple of occasions to contact healthcare staff to get input from someone from the mental health team, but he had been unable to get through to anyone. He did not know the man but had read through the ACCT document and the recent staff entries. The officer had sometimes spoken to the man on the unit in the weeks before.
59. The SO said the man seemed in very good spirits at the start of the review. He was smiling, fully engaged and said he had no thoughts of self-harm. He said he got on well with a couple of members of staff and if he had such thoughts he would be able to talk to them. However, he told the SO that he would not be able to talk to other staff if these two officers were not on duty, and would probably self-harm. In view of this, the SO decided to continue the ACCT monitoring for another week so the man could develop a rapport with more staff. He said the focus of the meeting had been about self-harm and not suicidal feelings.
60. The officer said the man seemed quite upbeat during the review but appeared to be embarrassed about his self-harm behaviour. She did not think he had harmed himself for a while and remembered him saying, "If I'm going to do anything, normally I just do it and I don't tell anyone". She told him that as he knew staff better, he should talk to them instead. The officer thought the man was referring to self-harm, because until the night he died, the man had never made any serious attempts at suicide. They decided to maintain the same level of observations (one conversation in the morning, afternoon and evening) and considered there had been no increase in his level of risk for self-harm or suicide. They did not discuss anything about the meeting with the chaplain. After the review, the man telephoned his father and they spoke for ten minutes.
61. That afternoon, at 3.43pm, the man spoke to his mother for a few minutes. The conversation was mainly about his family. She said he did not sound very bubbly and he replied that he was not, but he was okay. The man asked his mother to contact his solicitor to find out more about his forthcoming parole dates.
62. Just after the evening meal had been served, around 6.00pm, the man went to the office and asked for some plasters. The officer said he gave him some but established that he had not cut himself. The man returned shortly afterwards and handed in some razors which he said he did not need. While doing the roll check (count of prisoners) at 6.20pm, the officer went into his cell to check on him. He said he seemed fine and was watching television. The officer asked whether he had cut himself, even by accident. The man laughed and said no. He said he had felt like it, but decided not to and that was why he had handed in the razors. The officer noted this in the ACCT record. This was the last entry before the man died.

63. A prisoner said he was a good friend of the man. He said he had spoken to him several times during the day and described him as quite happy. The last time they spoke was before they were locked up for the night and he said the man gave no indication that he intended to harm himself. He said he was looking forward to getting his orders from the prison shop the next day.
64. An officer was the patrol officer on unit four after prisoners were locked up, until the night officer came on duty between 8.20pm and 8.45pm. At 7.00pm, the patrol officer was checking another prisoner subject to frequent ACCT checks, about six cells away from the man and checked him too. At that time, he was watching television. The officer did not make an entry in the man's ACCT, because the evening entry had already been made, but told the investigator that he had seen him at that time.
65. At about 8.30pm, while checking the other prisoner again, the patrol officer also decided to check the man. He looked into his cell, put the light on and saw the man hanging from his upturned bed, with a canvas belt used as a ligature. The patrol officer radioed an emergency message using the words "assistance required". He thought he had also said, "I've got someone hanging". The control room recorded the time as 8.33pm. The patrol officer decided to enter the cell on his own because he felt preservation of life was more important than the need to wait for additional staff. He went in and held the man round his waist to keep him up off the noose and he expected the response officers to arrive soon.
66. Unknown to the patrol officer, there had been an assault on unit five, which is at the opposite end of the site. An ambulance technician was already in that unit treating an injured prisoner, accompanied by one of the designated response officers.
67. Another officer was the patrol officer on unit two (which covers C and D wing). The patrol officer from the next door unit was with her when the patrol officer's call came over the radio asking for assistance. She took that to mean that available staff needed to attend. The officer did not go initially because she was not a designated response officer.
68. The manager on duty said when he heard the first radio message, "assistance required" he asked the radio operator to get further details. The next message stated that a prisoner had a ligature around his neck. The manager said several staff reported that they were responding to the incident. He then asked for an emergency ambulance to be called and for the ambulance technician to go to unit four.
69. The patrol officer continued to hold the man but no one arrived. He did not hear any other staff acknowledge the initial radio message or say they were on their way. After a minute or so, he radioed again and said it was a code blue emergency and that he could not hold the man up much longer. The communications room radioed again for available staff to attend. The patrol officer described the man as pale and clammy but said the radiator was on

and the cell was quite warm. He then cut the ligature with his anti-ligature knife and laid him on the floor. He took out a mouth guard to begin resuscitation and saw that the man's lips were blue.

70. When the officer heard the second message, indicating a code blue, she told the other patrol officer that she was going to respond and asked him to cover her area. She then ran to unit four and arrived a few minutes later, about seven minutes after the patrol officer's first radio message. The man was lying on his back with his head facing the window and the patrol officer was putting his mouth guard over him. The officer began chest compressions and together they carried out cardiopulmonary resuscitation (CPR) until the ambulance technician arrived about seven minutes later. The time between the patrol officer discovering the man and her arrival was about 15 minutes.
71. The officer said she did not think about getting a defibrillator and, in any event, did not know where they were kept. She had not been trained to use one and had not had any emergency aid refresher training since she had started at the prison nine years earlier. She said she did about 15 chest compressions to every two breaths given by the patrol officer.
72. An operational support grade, arrived at unit four to begin a night shift and saw the officers carrying out CPR. He telephoned the centre office and was told that a paramedic was on her way to the wing. He directed her and other staff to the man's cell.
73. Two officers were with the paramedic on unit five. When they heard the code blue they took her to unit four. As several sets of gates have to be opened and closed, it took them about 15 minutes and they arrived at the cell between 8.45pm and 8.50pm. The paramedic had also been notified of the incident by the ambulance control room. When she got to the man's cell, the officers were still carrying out CPR. She said that his pupils were fixed and dilated (one of the signs that someone has died). She attached a defibrillator which did not advise a shock. The officer arrived and took over from the patrol officer, shortly followed by two other officers.
74. The officers and paramedic continued CPR for about 15 minutes before additional ambulance staff arrived at 9.02pm. An air ambulance landed outside the prison at 9.10pm and its medical team were at the man's cell at 9.20pm. The doctor from the air ambulance decided to stop resuscitation at 9.34pm and certified the man's death.

Debrief

75. The staff who had been involved in the efforts to resuscitate the man attended a debrief. They discussed the lack of response to the patrol officer's first call and concerns about how long he had been left holding the man's body. The care team and prison managers offered support.

Informing the man's family

76. The prison's family liaison officer and an operational manager left the prison soon after 11.00pm to break the news of the man's death to his family. They arrived at their home at around 1.00am. Some family members later visited the prison. Highpoint contributed to the funeral costs, in line with national policy.

Letters written by the man

77. The man left several letters in his cell addressed to members of his family and the prison. In a letter to the prison, he thanked the staff for getting him through Christmas but said that he could not cope anymore.
78. The man had also written a five page letter to the officer. We are uncertain when it was written or handed to staff, but another officer thought it was on 8 January. On the afternoon of 9 January he saw the letter, which had been placed in a desk drawer, and gave it to the officer. As she had been busy all day, she did not read it until much later that evening when she was the patrol officer on unit nine. As she was reading the letter, she heard the patrol officer's code blue message.
79. In the letter to the officer, the man recounted parts of his life, including some of what he had told the chaplain about his friends who had died. He said the death of his first friend had had a profound effect on him and had led to his fire-setting behaviour and prison. In prison he had gradually become more self-aware and realised that he could take control of his own life. He wrote about the mental health worker at Blundeston prison as having had a very positive influence on him and after the prison moves when Blundeston closed, "everything good went again" and he started self-harming and not trusting people again. He felt, "things are worse than ever before" but that every time he went to kill himself he stopped at the last minute. The man said he wanted help and did not want to kill himself, but was worried and scared. He said he was very grateful for all the time the officer had given him.

Post-mortem

80. The post-mortem report indicated the man died from hanging. There were no drugs in his system except for sertraline. He had a number of scars on his body in various stages of healing.

ISSUES

Mental health care

81. The clinical reviewer considered that the man's mental health was a major medical issue. He had been fully assessed at Aylesbury and Blundeston, where mental health nurses and psychiatrists saw him frequently and made entries in his medical record handing over his mental health care when he moved on.
82. When the man transferred from Norwich to Highpoint on 18 December 2013, he had the following issues:
 - An open ACCT plan.
 - He had recently been seen at hospital after an alleged overdose.
 - In the early hours of the day of his transfer, he had self-harmed.
 - He had been under the care of mental services periodically since the age of nine.
 - He had been under the care of a psychiatrist and mental health in-reach teams at both Aylesbury and Blundeston.
 - He had been prescribed an antidepressant.
83. The reception nurse who carried out the man's health screen at Highpoint was sufficiently worried to make an urgent referral for the mental health team to assess him that day. The community psychiatric nurse, who conducted the first and subsequent mental health assessments, described the man as quiet, pleasant and communicative. She did not contact the mental health staff who had previously cared for him for a handover about him but concluded that he had, "no common mental illness or severe and enduring mental illness". She did not discuss the man's referral with any other member of the mental health team as it was around Christmas time and several members of staff were on holiday.
84. The clinical reviewer indicates that it is normal practice in a community mental health team for all new referrals to be discussed at a multidisciplinary team meeting before the referral is allocated to a member of staff. If the prisoner has to be seen urgently, a community psychiatric nurse (CPN) would normally assess them and discuss the assessment at the next team meeting. This did not happen in the man's case. In spite of the factors listed above, the community psychiatric nurse wrote on 24 December that the man did not feel the need for mental health service involvement and therefore he would not be seen by the team at that time.
85. We agree with the clinical reviewer's opinion that, although the man had said he did not need the support of mental health services, his immediate past history of self-harm suggested he might have benefitted from the continuing help of the mental health team. The clinical reviewer concluded that the man's mental health care at Highpoint was weak as he had not been seen or reviewed by a doctor and the normal pathways of care had not been implemented. He considered that some aspects of his care would have been better in the community. We consider that the mental health team should

have been more proactive in considering his needs and offering him support. We make the following recommendation:

The Head of Healthcare should ensure that mental health team fully assess the needs of newly-arrived prisoners subject to mental health care, including:

- **Applying appropriate acceptance and discharge criteria;**
- **Contacting the prisoner's previous prison for a handover of care; and**
- **Discussing the prisoner's referral at a mental health meeting.**

Management of the man's risk of suicide and self-harm

Assessment of the man's risk of self-harm

86. PSI 64/2011, which covers safer custody and PSI 74/2011, Early Days in Custody both list a number of risk factors and triggers for suicide and self-harm. These include, transfers between prisons, early days in custody, mental health problems and a history of self-harm. PSI 74/2011 notes that all staff should be alert to the increased risk of suicide/self-harm posed by prisoners in those categories and act appropriately to address any concerns.
87. The man had a history of self-harm and had been managed under the ACCT suicide and self-harm prevention procedures a number of times. When he arrived at Highpoint, he was still subject to the ACCT procedures and the nurse who conducted his health screen was concerned that he was a high risk of further self-harm. It is therefore difficult to understand the rationale for the decision to close the man's ACCT at lunchtime on 19 December, the day after he arrived. He was a prolific self-harmer who had last harmed himself the previous day and staff at the ACCT case review, who did not know the man, went against the advice of the community psychiatric nurse who had recommended that he continue to be managed under the ACCT process until he had settled at Highpoint. No member of the healthcare staff were present.
88. The ACCT was re-opened later that day in response to the man handing in razor blades and telling staff he was tempted to self-harm but was closed again the next day. Again, we are surprised at this decision, particularly as the note of the case review indicates that he was feeling unsettled after the move from Blundeston.
89. The chaplain who spoke to the man for a considerable time on 7 January, thought he appeared better after talking to him. We believe he overlooked his increased risk factors and he put too much importance on the man's presentation. He did not write anything in the ACCT on-going record as he should have and he did not speak to any other staff involved in the man's care about the nature of what the man had disclosed. This was a missed opportunity to review the man's risk and offer him more support.
90. The case review on the day the man died did not identify any concerns about how he was feeling, and was not multidisciplinary. We know from his conversation with the chaplain two days earlier (and retrospectively from the

letter written to the officer) that the man appeared to be having some form of crisis at the time. It was unfortunate, but understandable, that the officer did not have time to read the letter the man had written to her until late in the evening, coincidentally, just as the patrol officer had found him hanging. Had the contents of the letter and the discussion with the chaplain been known, staff might have realised that the man needed increased support under the ACCT system.

91. Apart from the ACCT entries made by the officer, there was very little in the on-going record to suggest that staff had meaningful conversations with the man at Highpoint, particularly in the last week of his life. In general, the entries appear superficial and observational about what the man was doing at the time, rather than indicating any personal interaction. It is possible that some staff had more than a few words with him but this is not reflected in the document which should have been completed in more depth.
92. The investigation found that his case reviews had no input from the mental health team and decisions about level of risk and closing the ACCT were not soundly based. Apart from those of one or two officers, most of the entries in the man's on-going record were poor - lacking detail or evidence of any real interaction with him – a similar issue to that highlighted in HM Inspectorate of Prison's most recent report on Highpoint. The man had seven ACCT reviews during his time at Highpoint and for five of those reviews there was a different senior officer chairing. Such inconsistency in case management does not allow appropriate continuity of care and makes it difficult for the chair to know the issues about a prisoner and for the prisoner to feel confident enough to open up and share their feelings in a meeting with staff they do not know.

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

- **Continuity of management of ACCT case reviews;**
- **Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care;**
- **Completing ACCT documents fully and accurately;**
- **Considering all known risk factors when determining the level of risk of self-harm or closing an ACCT plan; and**
- **Holding a case review when significant new information about risk becomes known.**

Emergency response

Medical emergency response codes

93. Prison Service Instruction 03/2013, Medical Emergency Response Codes, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that, if an emergency code is called over the radio, an ambulance must be called

immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called. It also explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. A Governor's Order (08/2013) was issued at Highpoint on 13 March 2013, reiterating the requirements of the PSI.

94. Code blue is used where prisoners have trouble breathing or are unconscious. The patrol officer should have used this when he first found the man hanging. The officer said the phrase used by the patrol officer "assistance required" is taken to mean that all available officers must respond. She said that there was no point calling a code blue in the evening because the healthcare staff were not in the prison and that, in Highpoint, a code blue is not for uniformed staff to assist but is generally for healthcare to attend. However, a code blue should result in the control room calling an ambulance immediately.

Resuscitation efforts

95. The patrol officer and the officer made considerable efforts to help the man that evening. However, the clinical reviewer pointed out that the officers had used the incorrect ratio of breaths to chest compressions, 2:15, rather than 2:30 as recommended in current advice. Neither officer had had any recent updates in their CPR training.
96. It should be normal practice for a defibrillator to be taken to all code blue emergencies. There were no nurses on duty in the prison at the time the man was found and the officers interviewed did not know where the defibrillators were kept and had never received training in how to use them. There are four defibrillators on units in Highpoint South (in addition to two in the healthcare department). The one on unit three would have been the closest to the man. The officer passed this unit on her way to unit four but did not know it was there and said it had not crossed her mind to get one.
97. The clinical reviewer commented that it was likely that the man had been dead for sometime and use of a defibrillator would not have made a difference to the eventual outcome.
98. Although the patrol officer entered the man's cell immediately, there was a delay of seven minutes before another officer arrived to help which is unacceptably long and designated response officers were dealing with incidents elsewhere in the prison. It took 15 minutes before an ambulance technician, who was already in the prison, arrived at the cell. Some of the staff involved in the incident were unfamiliar with the guidance on emergency response codes and that a code blue should be used when someone is found hanging. They were unclear about their roles in an emergency and were unaware of the location of defibrillators. The officers who first responded had no up to date first aid training. We make the following recommendations:

The Governor should ensure that all prison staff are made aware of PSI 03/2013 and the local guidance and understand their responsibilities during medical emergencies, including ensuring that:

- All staff use the appropriate code to communicate a medical emergency;**
- Staff called to the scene arrive quickly, bring the relevant equipment including defibrillators;**
- Contingency plans provide for sufficient staff to be available in the event of more than one emergency incident occurring at the same time; and**
- There are no delays in calling, directing or discharging ambulances.**

The Governor should ensure that between 5.00pm and 8.00am when there are no healthcare staff present, there are sufficient staff on duty with up to date first aid and CPR training and confident about using a defibrillator.

RECOMMENDATIONS

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 - Applying appropriate acceptance and discharge criteria;
 - Contacting the prisoner's previous prison for a handover of care; and
 - Discussing the prisoner's referral at a mental health meeting.
2. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Continuity of management of ACCT case reviews;
 - Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care;
 - Completing ACCT documents fully and accurately;
 - Considering all known risk factors when determining the level of risk of self-harm or closing an ACCT plan; and
 - Holding a case review when significant new information about risk becomes known.
3. The Governor should ensure that all prison staff are made aware of PSI 03/2013 and the local guidance and understand their responsibilities during medical emergencies, including ensuring that:
 - All staff use the appropriate code to communicate a medical emergency;
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 - Contingency plans provide for sufficient staff to be available in the event of more than one emergency incident occurring at the same time; and
 - There are no delays in calling, directing or discharging ambulances.
4. The Governor should ensure that between 5.00pm and 8.00am when there are no healthcare staff present, there are sufficient staff on duty with up to date first aid and CPR training and confident about using a defibrillator.