Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean McCann a prisoner at HMP Peterborough on 13 March 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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 Sean McCann was found hanged in his cell on 13 March 2016 in the segregation unit at HMP Peterborough. He was 32 years old. I offer my condolences to Mr McCann's family and friends.

Mr McCann had self-harmed and threatened and attempted suicide at Peterborough and was being managed under Prison Service suicide and self-harm prevention procedures at the time of his death. I acknowledge that Mr McCann was a very challenging prisoner, but he was taken to the segregation unit without evidence that this decision was taken on an exceptional basis for someone at risk of suicide. Nor were the suicide prevention procedures managed effectively. Case reviews were not multidisciplinary and did not identify and put in place plans to reduce his risk. Staff did not use enhanced case review procedures which I would have expected for a prisoner who presented with such challenging behaviour. There were also deficiencies in mental health provision and the emergency response.

I am concerned that I am repeating concerns about suicide and self-harm prevention and emergency response at Peterborough which I have raised previously, and I expect the Director to address these issues as a matter of urgency.

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 **February 2017**

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Summary

Events

1. On 10 August 2015, Mr Sean McCann was remanded in custody to HMP Chelmsford for assault and other offences. He had been in prison before. He was monitored under suicide and self-harm prevention procedures (known as ACCT) for one day as he had threatened to self-harm while in police custody.

2. Mr McCann had depression, anxiety and a personality disorder, and had a history of substance misuse and self-harm. He was prescribed antidepressants and other medication. In October, staff suspected Mr McCann was using illicit substances, but took no further action.

3. On 7 October, Mr McCann was sentenced to two years in prison. He was distressed and was monitored under ACCT procedures for two weeks. Mr McCann was referred to a psychiatrist, who concluded that he did not have any serious mental health problems and discharged him to primary care services.

4. On 4 January 2016, Mr McCann was transferred to HMP Peterborough. On arrival, he said that he did not have any thoughts of suicide or self-harm but staff noted that he had been monitored under ACCT procedures at Chelmsford. He was referred to mental health services but missed his appointment. In January and February, staff suspected Mr McCann of misusing drugs and bullying other prisoners.

5. On 29 February, Mr McCann harmed himself and staff began ACCT procedures and moved him to the prison inpatient unit. Later that day, he tied a ligature around his neck. On 1 March, he was assessed as at a low risk of suicide and was discharged back to the wing.

6. On 3 March, staff received intelligence suggesting Mr McCann was involved in using and supplying drugs (including new psychoactive substances – NPS) and weapons on the wing, and was intimidating other prisoners. He was moved to the segregation unit, where he was disruptive and damaged his cell. Staff removed ligatures he had made from his cell. There is no record of anyone considering whether he could safely be located anywhere else in the prison, or, crucially, that there were exceptional circumstances for his continued segregation while on ACCT procedures. It is noteworthy that the segregation unit was, at that time, holding a further five prisoners subject to ACCT procedures.

7. Mr McCann returned to a standard wing on 7 March, but two days later was segregated again after threatening staff and prisoners. Again, no one recorded that there were exceptional reasons to segregate him while he was on ACCT procedures. On 10 March, he tied a ligature around his neck, but he was considered too volatile to be admitted to the inpatient unit. Staff checked him five times an hour but did not hold an ACCT case review.

8. On 12 March, Mr McCann attended a segregation review and an ACCT case review, and his mental health was assessed. Staff had no particular concerns about him, although, again, they suspected he was under the influence of NPS.

They took no further action in response, and did not discuss his suicide attempt two days earlier.

9. On the afternoon of 13 March, Mr McCann said he wanted to kill himself. He was seen alive at 6.25pm, but, by 6.50pm, had covered the observation panel in his cell door and did not respond to officers, who did not immediately raise the alarm. At 7.06pm, officers went into Mr McCann's cell and found him unresponsive and hanging from a broken light fitting. Officers, nurses and paramedics tried to resuscitate Mr McCann, but he was pronounced dead at 7.44pm.

Findings

10. We do not consider that the prison managed Mr McCann's risk of suicide or self-harm effectively and in line with national Prison Service instructions, including a lack of healthcare input. Prisoners assessed as at risk of suicide and self-harm should be segregated only in exceptional circumstances but no one recorded the exceptional reasons for Mr McCann's segregation and there is no record that anyone considered whether any alternative accommodation in the prison would have been more appropriate.

11. There is no evidence that anyone held an enhanced case review, which, given Mr McCann's risky and volatile behaviour should have been considered. This would have required more senior staff involvement and a multidisciplinary holistic review of his care.

12. We are concerned that the mental health team did not assess or manage Mr McCann's mental health before he was segregated.

13. Officers did not immediately raise the alarm when they found Mr McCann had covered his observation panel and would not respond on 13 March, as they should have, and the emergency medical equipment was faulty.

14. There was considerable security information suggesting that Mr McCann was using illicit substances, dealing drugs and weapons at the prison and intimidating, assaulting and bullying other prisoners. We did not find evidence of a clear strategy to manage these risks, other than to segregate him, and staff did not follow the prison's protocol when they suspected he had used NPS.

Recommendations

- The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including ensuring that:
    - Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
    - Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate and healthcare staff attend all first case reviews.
    - Staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.

    - Staff set ACCT caremap actions which are aimed at reducing prisoners' risks to themselves and review them at each case review.
    - Staff use enhanced case management procedures for prisoners held in unfurnished accommodation and in other more complex cases.

- The Head of Healthcare should ensure that prisoners referred to the mental health teams have timely, appropriate, face- to-face assessments in private and mental health management plans are drawn up when necessary.

- The Director should ensure that all staff understand their responsibilities under the local security strategy when they find a prisoner has obscured his observation panel.

- The Healthcare Manager should ensure that staff check emergency response equipment regularly and after each use and that the checks are recorded.

- The Director should ensure that staff consistently follow a clear pathway for managing prisoners suspected of using NPS and other illegal substances, and that security intelligence information is acted on quickly and investigated where necessary.

The Investigation Process

1. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact her. Three prisoners wrote to the investigator and she interviewed one of them.

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

3. The investigator visited Peterborough on 16 March 2016. She obtained copies of relevant extracts from Mr McCann's prison and medical records. She and the clinical reviewer interviewed 16 members of staff and a prisoner at Peterborough on 28 April, 3 and 12 May.

4. We informed HM Coroner for Peterborough of the investigation and have sent him a copy of this report.

5. One of the Ombudsman's family liaison officers contacted Mr McCann's family and representatives. They raised no further issues for the investigation and had no comments on the initial report.

Background Information

HMP Peterborough

15. HMP Peterborough is privately operated by Sodexo Justice Services. It holds men and women in separate sides of the prison and has 24-hour health care provision. Cambridge and Peterborough NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons last inspected Peterborough in February 2015. They reported that most prisoners felt relatively safe, although those with disabilities and some other minority groups felt less so. The number of fights and assaults had declined. A system of early intervention to reduce violence had been implemented and was having an impact. Victims of bullying or intimidation received practical support.

17. The Inspectorate found that six per cent of the prison's population were from a Gypsy, Romany or Traveller background, in contrast to two per cent identified by the prison. Despite Travellers being under-identified, the Inspectorate considered that the prison supported them well.

18. They also reported that lessons learned from four self-inflicted deaths were being applied effectively, although a more integrated approach was needed. Staff understood and used the systems for monitoring and supporting those at risk of suicide and self-harm well.

19. Segregation was frequently used and multidisciplinary reviews took place at prescribed intervals. The Inspectorate found that few men assessed as at risk of suicide or self-harm were held on the segregation unit, and then only when necessary. All prisoners had care plans, staff in the unit knew prisoners very well and relationships were described as excellent. The report said that the unit's regime was reasonably good and prisoners could visit the gym and library, subject to risk assessment.

Independent Monitoring Board

20. Each prison 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 recently published report for the year to March 2015, the IMB commented that primary and secondary mental health teams worked well together, with good communication. They added that the 'alert' system continued to work well, so all staff could refer prisoners for a mental health assessment.

21. The IMB also said that the segregation unit continued to be well run, with committed and caring staff who handled volatile and challenging prisoners professionally. However, the IMB did not think that they were notified of prisoners being moved to the unit within 24 hours, one of the safeguards to ensure that the segregation unit is effectively monitored. The IMB spoke to all prisoners in the unit on their weekly rounds.

2. The IMB were satisfied that segregation reviews were conducted correctly with required staff members attending. The IMB attended as many reviews as they could.

Previous deaths at HMP Peterborough

22. Following prisoners' deaths in 2014 and 2015, we were concerned about the operation of the ACCT process at Peterborough. We were also concerned about the emergency response in both cases. It is disappointing that we have raised similar concerns in this investigation report.

Assessment, Care in Custody and Teamwork (ACCT)

23. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent he prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

26. NPS are an increasing problem across the prison and immigration detention estates. They are difficult to detect, as they are not identified in current drug screening tests. 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.

27. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.

28. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff 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.

Segregation unit

29. Segregation units (sometimes known as care and separation units, as is the case at Peterborough) are used to keep some prisoners apart from others. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by a prison operational manager who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are restricted and prisoners are usually permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

Key Events

HMP Chelmsford

30. On 10 August 2015, Mr Sean McCann was remanded to HMP Chelmsford charged with assault and other offences. He had been in prison before. Court staff noted on Mr McCann's Person Escort Record (PER – which accompanies prisoners when they move between police custody, court and prison) that he had been subject to constant supervision in police custody because he had threatened to choke himself with his solicitor's pen the day before. Reception staff began suicide and self-harm prevention procedures (known as ACCT).

31. At his initial health screen, Mr McCann told a mental health nurse in reception that he had depression, anxiety and a personality disorder, had seen a psychiatrist in the past two years, had been sectioned six years earlier and stayed in a hospital in Bedfordshire. He said he used drugs and so the nurse referred him to the substance misuse team. Although Mr McCann had a history of self-harm, he said he had no current thoughts of suicide or self-harm. The nurse recorded that Mr McCann was a Traveller.

32. A doctor examined Mr McCann that evening and prescribed him a diazepam detoxification regime because he misused benzodiazepines, mirtazapine (an antidepressant) and pregabalin for nerve pain.

33. Mr McCann saw a drug counsellor on 11 August. They discussed his mental health history and that he had been subject to ACCT monitoring in the past. Mr McCann said he did not need substance misuse services. Staff ended ACCT monitoring that day.

34. On 24 August, the nurse dispensing Mr McCann's medication thought he was under the influence of substances. Mr McCann said he had not taken anything. The nurse submitted a security incident report. On 4 October, an officer monitoring the medication dispensing saw Mr McCann pass one of his tablets to another prisoner. The officer completed another security incident report.

35. On 7 October, Mr McCann was sentenced to two years. He was distressed and told staff that he was going to cut his throat. Staff assessed that he was at risk of suicide or self-harm so started ACCT monitoring and referred him for a mental health assessment. At the mental health assessment on 9 October, Mr McCann told a nurse that he was hearing voices and wanted to rip his flesh off. The nurse referred him for further mental health assessment and he remained subject to ACCT monitoring. On 20 October, Mr McCann told a mental health nurse during an assessment that he had hallucinations and nightmares, and that he was very upset. The mental health nurse referred him for an urgent psychiatric assessment.

36. On 24 October, Mr McCann punched a wall and hurt his hand and, later that day, scratched his neck. He told staff he was frustrated, but said he had no thoughts of suicide or self-harm, as he only had a few months left to serve.

37. Mr McCann saw a psychiatrist on 3 November. He noted that Mr McCann found it hard to control his anger, but said he had no thoughts of suicide or self-

harm. The psychiatrist recorded that Mr McCann showed no evidence of a mental illness, depression or acute psychosis. Mr McCann said he had no more hallucinations. The psychiatrist concluded that Mr McCann did not have a severe and enduring mental illness and did not need ongoing psychiatric treatment. Mr McCann said he was happy to be discharged from the mental health team caseload.

38. On 8 December, staff assessed that Mr McCann's risk of suicide and self-harm had reduced and he no longer needed the support of an ACCT. Officers and healthcare staff agreed to stop ACCT monitoring, and held a post closure interview on 15 December, which confirmed that he was no longer at risk of suicide or self-harm.

39. Mr McCann was transferred to Peterborough prison on 4 January 2016.

HMP Peterborough from January 2016

40. When he first arrived at Peterborough, an officer noted that Mr McCann had previously been subject to ACCT monitoring, but officers had agreed that he was not at risk of suicide or self-harm at the time of his transfer. Mr McCann told her that he had no thoughts of suicide or self-harm.

41. At his transfer health screen, Mr McCann told a healthcare assistant about his history of suicide threats and self-harm, but he said that he had no thoughts of suicide or self-harm at that time. She could see from his medical records that he had been prescribed mirtazapine and pregabalin, and had seen the mental health team at Chelmsford, so she referred him to Peterborough's mental health team. A urine test detected that Mr McCann had used buprenorphine (also known as subutex - a drug to treat opiate addiction), which he had not been prescribed, so Ms Allen referred him to the substance misuse team. A prison GP continued his prescriptions.

42. A prison GP saw Mr McCann the next morning, 5 January, for a routine doctor's appointment. He noted that Mr McCann appeared to be under the influence of drugs, but he said he had only used subutex twice over the Christmas period and not recently. He noted that he would review Mr McCann when he was more clear-headed, but did not make another appointment.

43. An officer introduced herself to Mr McCann as his offender supervisor on 6 January. She told him that they would make plans for his release eight weeks before his release date, in April 2016. At this point, she said she would contact his offender manager and they would plan his housing and make other arrangements for his release.

44. Mr McCann completed his induction on 6 January. He moved to a wing for sentenced prisoners on 8 January.

45. Mr McCann was late for an appointment with the mental health team on 4 February. No one rebooked the appointment.

46. In January and February, staff submitted a number of security incident reports which indicated that Mr McCann might be involved in bullying and intimidating other prisoners. There is no evidence that staff took any action to investigate

this further or to monitor Mr McCann under tackling antisocial behaviour procedures.

47. On 29 February at 3.30pm, Mr McCann cut himself with a razor blade and tried to jump from the top landing with a ligature around his neck. Staff restrained him and he walked back to his cell. He said he needed mental health help. Staff began ACCT procedures and moved him to the prison inpatient unit. He was referred for a mental health assessment and staff checked him twice an hour.

48. A mental health nurse recorded that Mr McCann would not speak to her that afternoon. When a prison manager then tried to speak to him, he would not answer, but cut his arm and leg with a razor. He shouted out of the window that he was a Traveller and that he thought staff were treating him unfairly. Less than an hour after he cut himself, Mr McCann made a ligature and officers radioed a code blue (a medical emergency code used in circumstances, such as when a prisoner is unconscious or not breathing). They went into the cell and removed the ligature.

49. A prison GP assessed him and noted that he had blood on his arms and legs and held his hands over his face, but he told her he was fine. She could see red marks around his neck and his face was bruised, consistent with hanging or strangulation. Mr McCann said he had made a ligature from a ripped sock, tied it tightly around his neck and said that he had a razor blade in his mouth. Mr McCann tied things around his neck twice more that evening and healthcare staff decided he should be constantly supervised.

50. The next morning, 1 March, an officer assessed Mr McCann as part of ACCT procedures. Mr McCann said that he had spent almost a year in prison and was frustrated by his lack of sentence progression. Mr McCann said he did not know who his offender supervisor was, although his offender supervisor had already introduced herself and discussed plans for his release. Mr McCann also said that he had felt low in the past, but his friends on the wing had supported him. Mr McCann said he had children and a partner and felt he needed to live for them. He said that he had missed three mental health appointments as officers had not unlocked his cell.

51. At 11.00am, a Supervising Officer (SO), a manager in the inpatient unit, met Mr McCann and reviewed his risk of suicide and self-harm. No one from the healthcare team attended, contrary to national instructions. Mr McCann said he was frustrated because he was not working, but he did not want to kill himself because of his children. The SO assessed Mr McCann as at low risk of suicide or self-harm, reduced his observations to twice hourly and discharged him back to the wing. The only actions she identified to reduce Mr McCann's risk were to complete his induction and to see the mental health team. Mr McCann moved back to X2 Wing later that day.

52. On 2 March, Mr McCann became angry, punched a wall and cut his arm. Mr McCann refused treatment but asked for his medication to be reviewed. A nurse noted that she would book an appointment for him, although there is no record that she did. There is no evidence that anyone reviewed Mr McCann's risk of suicide or self-harm.

53. On 3 March, a member of staff submitted a security intelligence report that Mr McCann had appeared to be under the influence of drugs the previous day. Two further reports were submitted that day, that Mr McCann had two Stanley knives in his cell and that staff suspected he was using new psychoactive substances (NPS) and dealing them on the wing. Staff again noted that Mr McCann had been involved in several assaults and that up to 15 prisoners had asked to move away from the wing because they were frightened of Mr McCann. Later that day, staff decided that Mr McCann should be segregated in order to maintain the good order of the prison.

54. As Mr McCann refused to go to the segregation unit, officers handcuffed him and used force to move him. He chewed on a razor blade as officers escorted him and refused to remove it. When he arrived at the segregation unit, a nurse assessed him as he had hit his eye on the sink in his cell when the officers had restrained him. Mr McCann refused to let her look in his mouth to assess the damage from the razor blade. She told segregation unit officers that nurses could not go into Mr McCann's cell until he handed over the razor blade.

55. All prisoners who are segregated and assessed as at risk of suicide or self-harm should have a mental health assessment. A mental health nurse tried to assess Mr McCann's mental health through the segregation cell door, but he did not want to talk to her. He still had the razor blade in his mouth. She advised segregation unit staff to increase ACCT observations from every 30 minutes if he started to self-harm. She recorded that she also asked officers to remind him that he could speak to Samaritans or Listeners if he needed support. (Listeners are prisoners trained by the Samaritans to support other prisoners.) Finally, she suggested that staff consider whether Mr McCann should move to the inpatient unit if he remained at high risk of suicide or self-harm.

56. Including Mr McCann, there were six prisoners in the segregation unit assessed as at risk of suicide or self-harm and subject to ACCT monitoring that day. Mr McCann flooded his cell and blocked his observation panel. He said he wanted tobacco. Segregation unit staff went into his cell at 3.30pm to clear up the water and found the razor blade in the water. Staff saw that Mr McCann had made a ligature, which was not around his neck, and removed that too. There is no evidence that anyone reviewed Mr McCann's risk of suicide or self-harm, contacted the mental health team or considered increasing the frequency of Mr McCann's observations.

57. That evening, Mr McCann refused to take his medication, repeatedly blocked his observation panel and threatened to incite other prisoners to disrupt the segregation unit. He flooded his cell, was abusive to staff and said he wanted tobacco. He eventually took his medication, but repeatedly told staff that he had cut himself, even though they could see no evidence of this. Officers found a strip of material that Mr McCann said he was going to make into a ligature. Still, no one reviewed his risk of suicide or self-harm or contacted the healthcare team to discuss whether it was appropriate to continue to segregate Mr McCann.

58. A SO, the segregation unit manager, met Mr McCann on 4 March, for his second ACCT case review. They were the only two attendees. Mr McCann did

not participate in the review, so the SO assessed him as at raised risk of suicide and self-harm and increased his observations to three an hour. The SO noted that Mr McCann was unhappy about being segregated.

59. Also on 4 March, a senior prison manager noted in Mr McCann's ACCT caremap that he had authorised Mr McCann's continued segregation. The security department asked for Mr McCann to be removed from the general population, as there was intelligence that he was bullying and threatening prisoners and threatening staff. He said that Mr McCann could not reside in the prison's inpatient unit, but did not explain why. He also noted that the mental health team had agreed that Mr McCann could remain in the segregation unit. The prison could not find the segregation papers relating to Mr McCann's segregation from 3 to 7 March.

60. A SO attempted to engage Mr McCann in a third case review on 5 March. He recorded that Mr McCann threatened to assault staff and throw excrement over them, and had spat through the cell door. The SO noted that he would try to hold a case review the following day.

61. Later that day, a nurse assessed Mr McCann, after he punched his cell door following an upsetting telephone conversation with a family member. She suspected he had broken a knuckle so strapped his right hand and gave him painkillers. Throughout the day, Mr McCann banged his door, tried to set the fire alarm off with lighted toilet paper, threatened staff with excrement and said he had a razor blade. Mr McCann refused to speak to the chaplain and shouted at staff.

62. On 5 March, a manager carried out a routine quality check on Mr McCann's ACCT document and noted that no one from the mental health or general healthcare departments had attended any of Mr McCann's reviews, despite mental health having been noted as a trigger for his self-harm. The manager asked that this be addressed at Mr McCann's next review.

63. Despite the manager's instruction, on 6 March, a SO tried to hold the fourth ACCT review with Mr McCann on his own. Although Mr McCann said he felt very low in mood, he was also angry and threatened the SO with his flask. The SO noted that it was not possible to hold a review, but that a multidisciplinary segregation review was scheduled for 7 March, so staff should combine this meeting with an ACCT review. That evening, Mr McCann covered the observation panel in his door and complained that he was being treated unfairly.

64. On 7 March, a senior prison manager chaired a segregation review with a SO, a nurse from the mental health in-reach team, another nurse and Mr McCann. Mr McCann said he had self-harmed because he felt he was not getting any help and had not been given any work. The staff told Mr McCann he would return to a standard wing that day and that someone from the in-reach team would see him. Mr McCann said he felt he had got answers to some of his questions and felt that he would no longer need to self-harm, as he did so for attention. Staff agreed that he was at lower risk of suicide or self-harm and reduced the frequency of checks to once an hour. Mr McCann moved to Y2 Wing that day.

65. On 9 March, staff decided to move Mr McCann back to the segregation unit because of further intelligence that he was involved in the trading of drugs and weapons, and had threatened to assault staff and prisoners on Y2 Wing. Mr Ward authorised Mr McCann's segregation until 12 March, in order to maintain the good order of the prison. A nurse completed a segregation health screen and assessed that Mr McCann could be segregated safely, without adverse effects to his mental health. He carried out the mental health assessment through Mr McCann's cell door. He recorded that Mr McCann had no thoughts of suicide or self-harm, but did not record any details about his mental health.

66. That afternoon, a SO held another ACCT review in the segregation unit, with a nurse and Mr McCann, who did not want to participate. The SO noted that they would hold another review the next day, when Mr McCann had settled into the unit. He increased the frequency of observations to three an hour.

67. On the morning of 10 March, Mr McCann threatened to assault staff if they opened his door and so staff told him that he would remain locked in his cell that day. In response, Mr McCann banged on his door, threatened staff and flooded his cell. A SO attempted to hold the next ACCT case review with Mr McCann but Mr McCann refused to take part. He assessed Mr McCann as still at a raised risk of suicide and self-harm and did not update the caremap.

68. At 5.30pm on 10 March, an officer noted in the segregation unit's observation book that Mr McCann had been found unresponsive in his cell with a piece of sheet tied around his neck and his observations had been raised to five an hour. A nurse was in the segregation unit at the time and went to his cell. Officers had already removed the ligature. The nurse roused Mr McCann by shouting and shaking him and gave him oxygen. Staff agreed that Mr McCann should remain in the segregation unit as he was considered too aggressive and volatile to move to the inpatient unit (and Mr McCann did not want to move because he would not be able to smoke). However, staff increased the frequency of observations to five observations an hour.

69. The nurse checked Mr McCann later that evening. He said he was fine but did not have any tobacco. She said she passed this information to an officer, but there is nothing further in his records to indicate that staff took any further action.

70. On 11 March, a chaplain visited Mr McCann, who asked for a Bible. Staff did not hold another ACCT review, despite Mr McCann's suicide attempt the night before.

71. At 8.20pm, Mr McCann told an officer that he was frustrated at being in the segregation unit and he did not understand why he was there. Officers just said he was there for security reasons. The officer reminded him that he had a segregation review meeting the next day, which might help him to understand. Mr McCann seemed happy with this and said he would not cause any trouble that night.

72. On 12 March, a mental health nurse completed a segregation health screen and a 24-hour mental health assessment and advised that Mr McCann could remain in the segregation unit, but he should be continually reviewed. She

noted that there was no evidence Mr McCann's mental health had deteriorated or that his risk of self-harm had increased, despite his recent behaviour, but that it could. She noted that he should not have any razors and to ensure he had something to do to keep him occupied. Mr McCann said he wanted the ACCT closed, but she recommended that it stay open for a little longer. She saw that Mr McCann's pupils were dilated and his speech was a little slurred. He indicated to an officer that he had taken Spice (an NPS) although he did not expressly say this.

73. A SO chaired an ACCT review attended by Mr McCann, and two nurses. Mr McCann said he had no thoughts of self-harm. They did not discuss his suicide attempt on 10 March. The SO noted that the inreach team had made an appointment to assess Mr McCann, and he was due to meet his offender supervisor to discuss his resettlement plan. Everyone present agreed to reduce the frequency of ACCT observations to during the night only and scheduled the next review for 18 March. He did not make any new entries on the caremap but noted that Mr McCann's offender supervisor had arranged to see him. Staff checked Mr McCann on the hour each hour during the night and he was subject to routine segregation checks during the day.

74. The same day, a senior prison manager chaired a segregation review with Mr McCann, two nurses and a SO. He agreed that Mr McCann should remain in the segregation unit. He recorded that there was evidence that Mr McCann was bullying, threatening and intimidating prisoners and had threatened to assault officers. He described Mr McCann's behaviour in the segregation unit as poor, because he had damaged his cell and threatened officers. He noted that Mr McCann was subject to ACCT monitoring, but did not reflect how his risk of suicide or self-harm had been considered in the segregation review.

13 March 2016

75. On the morning of 13 March, Mr McCann went to the gym, had his breakfast in his cell then went outside for some fresh air. Mr McCann had his dinner at midday, then asked a chaplain for a Bible again and the chaplain recorded in Mr McCann's ongoing ACCT record that he seemed a little stressed.

76. An officer recorded in Mr McCann's segregation record that Mr McCann said that he wanted to kill himself because staff were winding him up. The officer wrote that he continued to say that he wanted to kill himself all afternoon, but he eventually calmed down. The officer did not record this in the ACCT, no one contacted the mental health team or held an ACCT case review.

77. At 4.55pm, Mr McCann threatened segregation officers, a particularly SO, and said he could not manage another day in the segregation unit. An officer noted in his ACCT ongoing record that Mr McCann threatened to hang himself.

78. At 5.30pm, Mr McCann smashed the observation panel in his cell door with his flask, so officers moved him to a different cell. During the move, Mr McCann gave officers some strips of a sheet. At 5.55pm, a nurse gave Mr McCann his medication.

79. At 6.10pm, Officer A noted that Mr McCann was singing in his cell and last saw him at 6.25pm, when he was standing by the door shouting to other prisoners. At 6.50pm, Officer B carried out a routine check of prisoners in the segregation unit. CCTV shows that he went to Mr McCann's cell, but his observation panel was blocked and there was no response. There is no evidence that Officer B raised any concerns at this point.

80. Officer A went to Mr McCann's cell at 6.54pm to carry out an ACCT check. He told the investigator that Mr McCann had covered the observation panel and did not respond. He left the segregation unit to look through Mr McCann's cell window, but the cell was in total darkness. He went back to the segregation unit office and told Officer B that he was worried about Mr McCann, so they got a torch and went back to Mr McCann's cell.

81. Officer B opened the inundation port on the cell door and shone his torch through. He managed to clear the observation panel and saw Mr McCann on the floor with a sheet around his neck tied to a broken light fitting. He shouted to Officer A to call a code blue and they went into the cell. Officer A radioed a code blue at 7.06pm. The officer in the control room called an ambulance immediately. A nurse got to Mr McCann's cell at 7.08pm, checked him for signs of life, but found none. She asked officers to bring oxygen and the defibrillator. The first two bottles of oxygen were empty, but the third was full and she administered oxygen. When she attached the defibrillator, it advised to continue resuscitation.

82. The first paramedics arrived at the segregation unit at 7.15pm, and another team arrived at 7.25pm. A doctor pronounced Mr McCann's death at 7.44pm.

Contact with Mr McCann's family

83. An officer and a chaplain, the prison's family liaison officers, initially went to the wrong address, but eventually arrived at Mr McCann's parents' house at 1.30am, where they broke the news of Mr McCann's death. The prison contributed to the cost of Mr McCann's funeral, in line with Prison Service instructions.

Support for prisoners and staff

84. After Mr McCann's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

85. The prison posted notices informing other prisoners of Mr McCann's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr McCann's death. Two prisoners were moved from the segregation unit to the inpatient unit as a result of the review.

Post-mortem report

86. A preliminary post-mortem report on 16 March, concluded Mr McCann had died of asphyxiation by hanging. A toxicology report detected levels of mirtazapine

and pregabalin in Mr McCann's blood, medication he had been prescribed. It also detected NPS in Mr McCann's blood.

Findings

Managing Mr McCann's risk of suicide and self-harm in the segregation unit

87. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include being charged with a violent offence, a history of self-harm and suicide attempts, a history of substance misuse, diagnosed mental health conditions and irrational and hostile behaviour. Staff had identified that Mr McCann was at risk of suicide and self-harm and he was subject to ACCT monitoring when he died. We have concerns about the management of his risk.

88. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires that prisoners assessed as at risk of suicide and self-harm should only be held in segregation units in exceptional circumstances and that the reasons must be clearly documented in the ACCT record and include other options that were considered but discounted. Mr McCann was not in the segregation unit when the ACCT was opened but moved there very shortly afterwards because of security concerns. There was nothing in the ACCT document or his segregation file to indicate that staff recognised that this was exceptional or that any other options had been considered.

89. In a Learning Lessons Bulletin we issued in June 2015, we examined learning from investigations into the self-inflicted deaths of prisoners who were segregated at the time of their deaths. We noted that segregation reduces some protective factors against suicide and should be used only in exceptional circumstances for those at risk of suicide. When prisoners at risk are held in segregation, there are additional required safeguards, such as holding a mental health risk assessment within 24 hours and we discuss this in the following section.

90. PSI 64/2011 expects ACCT case reviews to be multidisciplinary where possible and there is a mandatory requirement that healthcare staff must attend the first case review. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff. Most of Mr McCann's case reviews were conducted by one supervising officer and the mental health team only contributed to two reviews, despite ongoing concerns about Mr McCann's mental health. Mr McCann's caremap did not consider how to mitigate the impact of prolonged segregation on Mr McCann, or include other specific actions which might have helped reduce his risk of suicide or self-harm.

91. PSI 64/2011 instructs that a case review should be held when there are additional concerns. We consider that staff should have considered holding a case review on the many occasions that Mr McCann cut himself or threatened to kill himself, but particularly on 10 March when he tried to kill himself. On the last occasion, the nurse and segregation unit staff agreed to increase the frequency of checks to five times an hour, but no one held a case review to consider Mr McCann's level of risk. There is no record that staff at the ACCT case review on 12 March, discussed Mr McCann's attempted suicide with him.

92. PSI 64/2011 says that prisoners whose behaviour is particularly challenging and disruptive should be managed under an enhanced ACCT case management process. In light of the security concerns and Mr McCann's challenging behaviour, we would have expected staff to consider using these procedures. In order to deal with disruptive prisoners assessed at risk of suicide or self-harm, staff need to make a full and proper assessment of all aspects and causes of their behaviour. The enhanced case management approach would have helped staff to consider Mr McCann's risk to himself and to others, more critically and holistically. More effective management of standard ACCT procedures would have ensured a multidisciplinary approach to managing Mr McCann's risk. We make the following recommendation:

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

- **Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.**
- **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate and healthcare staff attend all first case reviews.**
- **Staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.**
- **Staff set ACCT caremap actions which are aimed at reducing prisoners' risks to themselves and review them at each case review.**
- **Staff use enhanced case management procedures for prisoners held in unfurnished accommodation and in other more complex cases.**

Mental health

93. Mr McCann was diagnosed with a personality disorder, anxiety and depression and was prescribed antidepressants when he first arrived in prison. His prescription was continued in prison and he received mental health treatment in Chelmsford. When Mr McCann arrived at Peterborough, the reception nurse referred him for a mental health assessment, but he missed an appointment with the mental health team on 4 February, and it was not rebooked. Mr McCann apparently refused to speak to a mental health nurse on 29 February. The clinical reviewer concluded that there was no on-going review of Mr McCann's mental health needs. Neither did staff seek a diagnosis or create a plan to manage his mental health. We make the following recommendation:

The Head of Healthcare should ensure that prisoners referred to the mental health teams have timely, appropriate, face- to-face assessments in private and mental health management plans are drawn up when necessary.

94. A qualified healthcare professional must complete an initial segregation health assessment for all segregated prisoners, and a mental health nurse assessed Mr McCann as suitable to be located on 3 March and 9 March. This is not a full mental health assessment but a snap shot assessment of a prisoner's mental health, aimed at excluding very mentally unwell, suicidal prisoners from

segregation. However, as noted earlier, when prisoners at risk are held in segregation, a mental health risk assessment should be carried out within 24 hours of segregation. On 3 March, Mr McCann refused to speak to a mental health nurse and on 9 March, another mental health nurse recorded that he had assessed Mr McCann through the cell door, but recorded no detail of his assessment in Mr McCann's medical record or ACCT plan. On 12 March, a mental health nurse carried out an assessment and concluded that Mr McCann could continue to be segregated and there were no signs that his mental health had deteriorated or that his risk of suicide had increased.

Emergency response

95. Officer A said that Mr McCann was standing at his cell door shouting to other prisoners at 6.25pm on 13 March. At about 6.50pm, Officer B carried out a routine check of prisoners in the segregation unit. The observation panel in Mr McCann's cell door was covered and he did not respond to the officer. The prison's local security strategy instructs that if a prisoner obscures his observation panel during patrol state, or when they cannot be unlocked without three or more staff present (as was the case for Mr McCann), staff should radio the duty prison manager to arrange for additional officers to attend before going into the cell. There is no evidence that Officer B raised any concerns with the duty manager when he found Mr McCann's observation panel covered. We make the following recommendation:

The Director should ensure that all staff understand their responsibilities under the local security strategy when they find a prisoner has obscured his observation panel.

96. The emergency response nurse found that the first two bottles of oxygen she tried to use were empty. We make the following recommendation:

The Healthcare Manager should ensure that staff check emergency response equipment regularly and after each use and that the checks are recorded.

New psychoactive substances and security intelligence

97. Mr McCann's records showed he had a history of substance misuse, including new psychoactive substances (NPS). On several occasions staff suspected that Mr McCann was under the influence of substances, was involved in trading drugs and weapons and was linked with the bullying and intimidation of other prisoners. Staff submitted a number of security information reports and these resulted in him being segregated. We are concerned that the prison did not devise a strategy, other than segregation, to manage Mr McCann's risks, or to investigate the matters further.

98. Peterborough has an NPS protocol which outlines the actions staff need to take if a prisoner is suspected of taking Spice, or is exhibiting symptoms that they may have taken an illicit substance. Mr McCann was not monitored in line with the protocol at any stage and was not referred to substance misuse services. We make the following recommendation:

The Director should ensure that staff consistently follow a clear pathway for managing prisoners suspected of using NPS and other illegal substances, and that security intelligence information is acted on quickly and investigated where necessary.

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