Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Ruth a prisoner at HMP Leeds on 17 January 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.

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We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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 Michael Ruth was found dead in his cell at HMP Leeds on the morning of 17 January 2016, after strangling himself with a torn sheet. He was 42 years old. I offer my condolences to Mr Ruth's family and friends.

Mr Ruth had a history of drug and alcohol misuse, and had previously lost a leg due to medical complications after injecting drugs. He had served a number of sentences at Leeds before. He had diagnosed mental health problems and his behaviour in prison and in the community was often difficult to manage. In prison, he constantly demanded tobacco. I am satisfied that Mr Ruth received an appropriate standard of healthcare at the prison and proper support for his disability.

Mr Ruth had a range of factors which increased his risk of suicide and it is not clear that all these were recognised. I consider that a more wide-ranging assessment of his risk on 15 January, when Mr Ruth was tearful and threatened to kill himself because he did not have any tobacco, might have led to staff beginning suicide and self-harm prevention procedures. However, I recognise that it would have been very difficult to indentify that Mr Ruth was at high and imminent risk of suicide at the time.

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 **December 2016**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 5
Findings 10

Summary

Events

1. On Friday 8 January 2016, Mr Michael Ruth was sentenced to 16 weeks in prison and sent to HMP Leeds. He had served several previous sentences at Leeds. Mr Ruth had longstanding drug and alcohol problems and had undergone a leg amputation because of complications of drug misuse. He suffered from epilepsy and mental health problems, including schizophrenia. (His earlier medical records indicate that he had previously reported a history of self-harm and suicide attempts.) Nurses noted his medical conditions at initial health assessments and found no sign that he was suffering from withdrawal symptoms from alcohol or drugs. They also noted that he had missed a weekly depot injection of antipsychotic medication on Tuesday 5 January and this was subsequently administered, after the weekend, on Monday 11 January. No one assessed Mr Ruth as at risk of suicide or self-harm when he arrived at the prison.

2. Mr Ruth's behaviour in prison and in the community was sometimes very difficult to manage and often violent. In prison, he compulsively asked for tobacco. On 11 and 12 January, he broke the glass in the cell door observation panel and demanded tobacco. He continued to bang on his cell door for tobacco at intermittent periods during the day and night.

3. On Friday 15 January, Mr Ruth was tearful and told a mental health nurse that he would hang himself if he did not get any tobacco. The nurse was concerned about him but, after discussing with a supervising officer, decided not to begin Prison Service suicide and self-harm prevention procedures, known as ACCT. She noted what Mr Ruth had said in the wing observation book to alert officers. The supervising officer spoke to Mr Ruth afterwards and was satisfied that there was no need to begin ACCT monitoring.

4. At about 10.30pm on the night of 16 January, Mr Ruth twice rang his cell bell and asked an officer for tobacco. The officer told Mr Ruth that he did not have any tobacco and that they would try to resolve the problem in the morning. Around midnight, the officer noted that Mr Ruth appeared to be asleep on the floor of his cell. As Mr Ruth often slept on the floor, the officer was not concerned. The officer next checked Mr Ruth at 5.15am, and again assumed he was asleep.

5. Around 9.20am, another prisoner looked into Mr Ruth's cell. He was concerned about his appearance and told a supervising officer that he thought Mr Ruth was dead. The supervising officer assessed Mr Ruth, also considered he had died, and phoned for help. He did not use an emergency medical code but the duty manager called one. Prison nurses responded and attempted to resuscitate Mr Ruth, despite noting clear signs of death. Paramedics arrived and, at 9.38am, recorded that Mr Ruth had died.

Findings

6. Mr Ruth had a range of risk factors which indicated he might have been at increased risk of suicide when he arrived at the prison on 11 January. It is not clear that these were all fully considered when staff assessed his risk, but we recognise that it was reasonable not to begin ACCT procedures at that stage. However, on 15 January, when Mr Ruth was tearful (which was noted to be out of character) and threatened to hang himself, we consider that staff should have reviewed all his risks and begun ACCT monitoring. While this should have provided extra support, we accept that there was little to indicate that Mr Ruth was at high and imminent risk of suicide at the time and it would have been difficult for staff to have predicted or prevented his actions.

7. We are satisfied that Mr Ruth received an appropriate standard of healthcare at the prison, equivalent to that he might have expected to receive in the community. He was promptly referred to the disability liaison team, to a physiotherapist and to the mental health and substance misuse teams. As it was the weekend when he arrived, there was a delay until Monday in him receiving an injection of antipsychotic medication which he had missed in the community. However, it is likely that the same would happen in the community where there is only crisis cover at weekends.

8. Although the officer who found Mr Ruth unresponsive and apparently dead in his cell did not immediately use a medical emergency code, we are satisfied that this was quickly rectified and the there was a quick emergency response. As it was apparent that Mr Ruth had died; we do no consider that staff should have tried to resuscitate him.

Recommendations

- The Governor and Head of Healthcare should ensure that staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular:

    - Staff should have a clear understanding of their responsibilities and the need to record all relevant information about risk when making decisions.
    - Staff should begin ACCT procedures when a prisoner has expressed suicidal intent and has other significant risk factors.
    - All staff who have contact with prisoners should have appropriate ACCT training.

- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate

The Investigation Process

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

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

11. The investigator visited Leeds on 1 February 2016 and obtained copies of relevant extracts from Mr Ruth's prison and medical records. He viewed footage from body-worn cameras worn by two members of staff who were involved in the emergency response. There was no CCTV coverage of Mr Ruth's wing.

12. The investigator interviewed five members of staff and three prisoners at Leeds in February. The clinical reviewer joined him for interviews with healthcare staff.

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

14. One of the Ombudsman's family liaison officers contacted Mr Ruth's sister to explain the investigation. Mr Ruth's sister had no specific matters for the investigation to consider, but wanted the report to reflect that she was grateful for the support and advice that she had received from the prison's family liaison officer.

15. Mr Ruth's sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Leeds

16. HMP Leeds is a local prison holding up to 1,120 men. Leeds Community Healthcare Trust runs primary healthcare services. The prison has an inpatient facility with 24 hour nursing care.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Leeds was in December 2015. Inspectors were concerned about safety at the prison. They found frailties in early days processes and were not assured that the many vulnerable men who arrived at the prison received appropriate care. Inspectors noted that there had been several self-inflicted deaths at the prison since the last inspection in 2013 and the Prisons and Probation Ombudsman had identified problems with early days care and emergency procedures, not all of which had been addressed. ACCT suicide and self-harm prevention procedures needed improvement. Health services were generally reasonable. Primary mental health services were limited but specialist secondary mental health services were generally effective. Support for prisoners with disabilities was variable.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2015, the IMB was concerned about safety at the prison but noted that health services and social care were improving.

Previous deaths at Leeds

19. There have been six self-inflicted deaths at Leeds since the beginning of 2015. In previous investigations, we have identified concerns about the assessment of risk for new arrivals in reception, the management of ACCT suicide and self-harm prevention procedures and in emergency procedures.

Assessment, Care in Custody and Teamwork (ACCT)

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

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Key Events

21. On Friday 8 January 2016, Mr Michael Ruth was convicted of a number of offences at Magistrates' Court, including assaulting a police officer, theft, and using threatening, abusive and insulting words or behaviour. He was sentenced to 18 weeks imprisonment and taken to HMP Leeds. He had been at the prison a number of times before, most recently in April 2015.

22. Mr Ruth had a chaotic lifestyle. He was well-known to the authorities and was often seen begging in Leeds city centre. He had a record of assaulting prison officers, police officers, nurses and damaging property. He had a history of misusing drink and drugs. In 2005, his left leg had been amputated, because of medical complications caused by injecting drugs into his groin, and he used crutches to get around. He had epilepsy, and suffered from mental health problems, including schizophrenia. During a previous prison sentence in 2011, he had reported a history of self-harm and suicide attempts.

23. During previous periods in prison, Mr Ruth had been obsessively preoccupied about getting tobacco and asked for it constantly. At a previous prison, staff had tried to manage this by rationing his access to his tobacco to prevent him from smoking it all at once.

24. Mr Ruth had previously been managed under Prison Service suicide and self-harm prevention procedures, known as ACCT, several times. This was usually because he had been assessed as at high risk of suicide or self harm or had not been taking his medication correctly, rather than because of any actual incidents of self-harm in prison.

25. When he arrived at Leeds, his escort documents recorded that he could be violent, had previously tried to escape, was a drug user, was on the sex offender register, and had previously taken an overdose. Reception officers noted that he should have a single cell because of his mental and physical health problems. Mr Ruth refused to sign his induction papers. Staff did not allocate him a prison telephone account, as he had an outstanding non-contact court order and any telephone numbers he wanted to phone would need to be vetted. At a basic custody screen to identify his immediate needs, he said that he had committed the offences, with the intention of being sent to prison.

26. At an initial health screen, a drug test was positive for cocaine. A nurse recorded that Mr Ruth had epilepsy, schizophrenia, psychiatric problems and a history of self-harm. She noted that he had missed a weekly depot injection of antipsychotic medication, which had been due on Tuesday, 5 January. She knew Mr Ruth from previous times at Leeds and considered he appeared in better physical health, although he had neglected his personal hygiene. She used a standard assessment tool and did not consider Mr Ruth was at risk of suicide or self-harm. She said Mr Ruth was cooperative, polite and pleasant.

27. On 9 January, at a second more detailed health screen, a nurse noted Mr Ruth's physical disability, his epilepsy and schizophrenia. She had no concerns that he was at risk of suicide or self-harm. She recorded that he would need a cell with level access and notified the disability liaison team,

28. That afternoon, A nurse from the substance misuse team assessed Mr Ruth and noted his history of drug use. He recorded that Mr Ruth appeared stable. He reviewed him the next day to draw up a care plan and noted that Mr Ruth appeared stable, with no signs of drug withdrawal.

29. On Monday 11 January, a nurse referred Mr Ruth to the mental health team after an initial mental health assessment. She recorded that he had engaged appropriately but he looked unkempt and had not looked after his personal hygiene. He said he had no thoughts of suicide or self-harm. She went to get authorisation from the doctor to give him his antipsychotic depot injection. When she came back to the wing, Mr Ruth was shouting at a prison officer who was constantly supervising a prisoner at risk of suicide. Mr Ruth demanded a kettle, and said that he was the one who should be constantly watched. He did not answer when she asked him why. He continued to be irritable but stopped shouting and she took him for his depot injection.

30. A nurse assessed Mr Ruth's disability needs and he told her that he was fully independent. She noticed that his hygiene was poor and arranged for him to go to H Wing three times a week for an assisted shower.

31. Mr Ruth moved from the first night centre to F Wing that afternoon. Shortly afterwards, he broke the glass in the observation panel of his cell door with one of his crutches. He broke the crutch in the process. Officers moved him to another cell. The next afternoon, 12 January, Mr Ruth smashed the observation panel in the new cell and said he wanted some tobacco.

32. On 13 January, Mr Ruth was taken to H Wing for an assisted shower and personal care. At first he was reluctant to be helped and was aggressive, and verbally abusive towards the health support worker. However, he settled down and accepted help. Later that morning, a physiotherapist assessed Mr Ruth and the damage to his crutch. As both of Mr Ruth's crutches were badly worn, he gave him two new ones, and adjusted them.

33. That afternoon, a Supervising Officer (SO), demoted Mr Ruth to the basic level of the incentives and earned privileges scheme, which is designed to encourage responsible behaviour. She told the investigator that she had no concerns about Mr Ruth's emotional wellbeing at that time.

34. Through the night of 14/15 January Mr Ruth repeatedly banged on his cell door and disturbed other prisoners and staff. A member of staff noted in the wing observation book that another prisoner had threatened to throw boiling water at Mr Ruth through the broken observation panel, if he did not stop the noise.

35. On Friday 15 January, the mental health team allocated Mr Ruth to a nurse's caseload. She knew Mr Ruth from previous sentences. That afternoon she was on his wing, when Mr Ruth called her to his cell and asked her if she could get him some tobacco. When she told him that was not possible, he became tearful. He said that he would hang himself if he did not get any tobacco. She said that she knew that Mr Ruth had been manipulative in the past, and she had seen him get angry before, but she had never seen him cry. She said that the prison used to have tobacco for healthcare staff to give prisoners who were particularly distressed but this was no longer the case. She asked a prisoner

she knew, who was passing by at the time, whether he had a 'roll-up' he could give Mr Ruth, but he did not have one.

36. The nurse told the investigator that she then spoke to a SO about whether to begin ACCT monitoring, but the SO had seemed reluctant and believed Mr Ruth was being manipulative. The SO told her that he had been shouting, causing problems, and been put onto the basic regime. The SO said that the nurse had told her she was concerned about Mr Ruth because he had been tearful. The SO said that she had asked the nurse whether they should begin ACCT procedures but the nurse said that she knew he was manipulative and decided against it.

37. The nurse recorded what Mr Ruth had said in the wing observation book so that officers on the wing would be aware. She told the investigator that she did not think that Mr Ruth's threat to kill himself was serious. She had planned to review him on Monday 18 January.

38. The SO also made an entry in the wing observation book, noting that she had spoken to the nurse and they had decided it was not necessary to begin ACCT procedures. She added that someone from the resettlement team had come to see Mr Ruth but he had declined any help. After speaking to the nurse, the SO went to see Mr Ruth and he told her he was fine. She asked him about what he had said to the nurse. She said that she had heard that he had been upset, and asked whether there was anything she could do to help. She said he had told her he was fine and that she saw no signs that he was distressed; he was not crying, and did not have red eyes. She had no concerns about him and saw no reason to begin ACCT procedures. She said that she went to see Mr Ruth again before she had finished her shift. He was eating his meal at the time and told her that he was all right.

39. The next day, Saturday 16 January, the SO was on duty again. Mr Ruth went to see her in the wing office and asked her for some tobacco. She said that she could not authorise extra tobacco at the weekend, but if he spoke to wing staff on Monday, they would contact the finance department to see if they could arrange for him to access some funds to buy tobacco. She said that Mr Ruth accepted this, and she did not see him again that day.

40. That night there was a prison officer on duty on F Wing. At approximately 10.25pm, Mr Ruth rang his cell bell and asked him for a cigarette. The officer told him that he did not smoke and could not help. Shortly afterwards, Mr Ruth pressed the cell bell and asked for a cigarette again. The officer said that he had no tobacco. He told Mr Ruth that he should get some sleep and they would try to address the problem in the morning. The officer told the investigator that he saw nothing to make him concerned about Mr Ruth's safety and wellbeing.

41. Some time later, an officer was passing Mr Ruth's cell and looked in. (In a statement completed shortly after Mr Ruth's death, he said this was at 11.30pm. When we interviewed him, he said he thought it was after midnight.) He said Mr Ruth appeared to be asleep on the floor of his cell. He said he did not consider this was strange, as he was aware that Mr Ruth often slept on the floor.

42. The officer did not check Mr Ruth again until a roll count of all prisoners at approximately 5.15am. Mr Ruth was still lying on the floor, and the officer assumed he was still asleep. At 6.00am, he signed the record of the night patrol. This included confirming that he had checked all prisoners in single cells, although it did not specify the frequency of checks. He had checked Mr Ruth four times during his night duty. (However, he was unaware that there was a specific requirement to check prisoners in single cells and this is not reflected elsewhere in the prison's safer custody documents. The prison will need to clarify this expectation with night staff.)

43. Prisoners' cells on F Wing were unlocked at different times, depending on their job and their regime level. (Since Mr Ruth's death, the prison now requires officers to check the welfare of all prisoners at the time they unlock the first prisoners.) As Mr Ruth was on the basic regime, his cell was still locked when, at approximately 9.20am, another prisoner was passing his cell. He looked through the observation panel and saw Mr Ruth lying face down on the floor, with a pool of liquid on the floor around his head. He went to the wing office and told a SO that he thought Mr Ruth might be dead.

44. The SO and the prisoner went to Mr Ruth's cell. The SO looked through the observation panel and saw Mr Ruth lying on the floor with his foot up against the door. He called to him, but he did not respond, so he unlocked the door. Mr Ruth's foot was pressed against the door, so it was difficult to open. The prisoner helped him push it open far enough for him to squeeze through. Mr Ruth still did not respond and the SO noted that his arm was cold. He could not find a pulse.

45. The SO tried to radio for help but could not get a signal, so locked the cell and went back to the office. He then phoned the control room, and said he thought that a prisoner had died. The control room sent an emergency alarm across the radio network and called an ambulance. He telephoned the emergency response nurse and then the orderly officer in charge of the routine operation of the prison that morning. The orderly officer radioed a code blue medical emergency (which indicates circumstances such as when a prisoner is unconscious or not breathing) and went to F Wing.

46. Another SO responded to the alarm and went with the first SO to Mr Ruth's cell. She told the investigator that when she looked through the observation panel, she thought it was evident that Mr Ruth was dead. She went into the cell and moved Mr Ruth away from the door to allow two nurses to get in. They turned Mr Ruth onto his back and then found that he had tied a torn bed sheet around his neck, with the other end tied to his wrists. One of the nurses cut the sheet from Mr Ruth's neck.

47. The orderly officer had arrived and said that Mr Ruth's face was contorted, his skin discoloured, and his limbs were stiff. A nurse said that Mr Ruth felt cold, his skin was mottled, and rigor mortis had set in. She could not detect a pulse or any sign of breathing. Nevertheless, the nurses, and other healthcare staff who had arrived, began to attempt cardiopulmonary resuscitation, recorded at 9.24am. They attached a defibrillator, which found no shockable heart rhythm.

At 9.37pm, paramedics arrived, assessed Mr Ruth and, at 9.38am recorded that he had died.

Contact with Mr Ruth's family

48. An officer acted as the prison's family liaison officer. Twice that afternoon, he and the duty governor went to the address Mr Ruth had given for his sister, who he had named as his next of kin, to inform her of his death. Each time there was no one there, so the officer left a note asking her to contact him. At 7.30pm, Mr Ruth's called him and he told her that Mr Ruth had died.

49. The prison contributed to the cost of Mr Ruth's funeral, in line with Prison Service policy.

Support for prisoners and staff

50. After Mr Ruth's death, the duty governor debriefed the staff involved in the emergency response to allow them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

51. The prison posted notices informing other prisoners of Mr Ruth's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Ruth's death. Staff offered the prisoner who found Mr Ruth individual support.

Post-mortem report

52. A post-mortem examination found that Mr Ruth had died from pressure to the neck. There were no indications that he was under the influence of any illicit substances at the time.

Findings

Assessment of risk of suicide and self-harm

53. The Prison Service Instruction (PSI) covering safer custody, PSI 64/2011, lists a number of risk factors and potential triggers for suicide and self-harm. Staff should interview new prisoners in reception to assess their risk of suicide and self-harm. All staff should be alert to the increased risk posed by prisoners with these risk factors and should address any concerns, including opening an ACCT if necessary. Mr Ruth had a number of risk factors for suicide and self-harm, listed in the PSI, when he arrived at Leeds on 8 January. These included:

    - Low socioeconomic status
    - Unmarried
    - History of self-harm
    - Diagnosis of a mental illness (schizophrenia)
    - Contact with mental health inreach team
    - Recent contact with community psychiatric services
    - Physical illness
    - Impulsiveness
    - Lack of social support
    - Early days in custody
    - History of drug and alcohol abuse

54. In a Prisons & Probation Ombudsman (PPO) thematic report about risk factors for suicide and self-harm, published in April 2014, we identified the risk factors that staff need to take into account when assessing the risk of suicide and self-harm. We noted that people diagnosed with schizophrenia are twelve times more likely than others to kill themselves.

55. When Mr Ruth arrived at Leeds, a nurse noted his health problems and assessed his risk of suicide and self-harm using a standard reception health assessment tool. She did not consider he was at risk. The nurse noted that he was three days overdue for his weekly antipsychotic injection and would not get this until the next week, but does not appear to have considered whether this might have increased his risk. There is no record that risk factors, not covered by the assessment tool, were taken into account. The clinical reviewer noted that there is a need to take into account other known risk factors including those identified in PPO reviews and learning lessons material. Other than the nurse, there is no record that anyone else assessed Mr Ruth's risk of suicide and self-harm when he arrived, or as part of first night procedures.

56. There were a number of factors that suggested Mr Ruth might have been at risk of suicide or self-harm when he first arrived at the prison. We consider it would have been prudent to begin ACCT procedures until staff could satisfy themselves that Mr Ruth had settled, and at least until he had received his antipsychotic medication, as the affects on his state of mind were unknown. However, even though not all the risk factors were recorded, we recognise that the nurse considered most of the indicators of his risk and decided that he did not need ACCT monitoring at the time.

57. Mr Ruth's risk factors continued after he arrived, but there was little clear indication that his risk of suicide and self-harm had increased until 15 January, when Mr Ruth was tearful and told a nurse that he would hang himself if he could not get any tobacco. She knew Mr Ruth from previous sentences and was concerned about him as, although she believed he could be manipulative about getting tobacco, she had never seen him distressed to the point of tears before.

58. The nurse said she was familiar with the ACCT process but had never received any formal training. She discussed with a SO whether they should begin ACCT monitoring, but said the SO was reluctant, as she considered Mr Ruth was being manipulative. They decided not to begin ACCT procedures, but she noted her concerns about Mr Ruth in the wing observation book. The SO spoke to Mr Ruth shortly afterwards and did not consider he was in crisis and needed monitoring.

59. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. The PSI says that "any member of staff who … observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT".

60. Staff judgement is fundamental to the ACCT system, and they have to use their experience and skills to determine risk. This must include the prisoner's known risk factors and their presentation. We are concerned that Mr Ruth's comments on 15 January were considered in isolation of his existing risk factors. While we recognise that this was a difficult decision for staff, taken all together, we consider that his apparent distress and threat to kill himself should have tipped the balance in favour of beginning ACCT procedures. Although we cannot say that this would have prevented Mr Ruth's death, this would have allowed a further assessment of Mr Ruth's risk and helped ensure he received appropriate ongoing support. We recognise that there was little to indicate that Mr Ruth was at very high risk of suicide at the time, but where there is concern or significant doubt about a prisoner's safety, and the prisoner has evident risk factors, we consider that staff should begin ACCT procedures.

The Governor and Head of Healthcare should ensure that staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular:

- **Staff should have a clear understanding of their responsibilities and the need to record all relevant information about risk when making decisions.**
- **Staff should begin ACCT procedures when a prisoner has expressed suicidal intent and has other significant risk factors.**
- **All staff who have contact with prisoners should have appropriate ACCT training.**

Emergency response

61. When the SO went into Mr Ruth's cell, he said he checked his neck and wrist for a pulse but apparently did not notice Mr Ruth had ligatures made of torn sheets around his neck and wrist. He tried to radio an emergency but could get a radio signal. He therefore phoned the control room, the emergency response nurse, and the orderly officer.

62. The SO said he had panicked when he found Mr Ruth apparently dead and did not use the expected medical code blue, in line with the prison's emergency procedures. Ideally he should have done this, but we are satisfied that he conveyed the urgency of the situation and this did not cause any real delay. The orderly officer radioed a code blue as soon as he received the call from the SO and control room staff called an ambulance immediately.

63. Nurses responded promptly to the emergency, staff brought appropriate emergency equipment and used the correct resuscitation techniques. However, two nurses both said that there were clear signs of rigor mortis, and we do no consider it was necessary for the staff to have attempted resuscitation. Paramedics assessed that Mr Ruth was dead within a minute of arriving and said that it was clear from the rigor mortis in his jaw and hands that he had been dead for some time.

64. The European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" The guidelines define examples of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014m which said that every decision should be made on the basis of a careful assessment of each individual's situation and not by 'blanket' policies. Resuscitation should not be attempted when someone is clearly dead.

65. We accept that the nurses acted in what they considered to be Mr Ruth's best interests and do not criticise their actions. However, attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

Mr Ruth's healthcare

66. The clinical reviewer considered that Mr Ruth received good care in relation to his disability and other health needs. He was promptly referred to the disability liaison team, to a physiotherapist, to the mental health team and to the substance abuse teams. When he arrived at the prison it was a Friday. A nurse noted that Mr Ruth had not received his weekly depot injection in the community, which he should have had three days before. As the mental health inreach team does not work at weekends he did not receive this until the following Monday. The clinical reviewer noted that it is likely that this would have been the case in the community, as weekend cover is usually for crisis teams only. Overall, the clinical reviewer was satisfied that Mr Rush's

healthcare at the prison was equivalent to that which he could have expected to receive in the community.

Prisons & Probation Ombudsman

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