Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marcus McGuire a prisoner at HMP Birmingham on 24 April 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

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

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

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

On 24 April 2018, Mr McGuire was found dead in his cell at HMP Birmingham with a ligature around his neck. He was 35 years old. I offer my condolences to Mr McGuire's family and friends.

Mr McGuire was admitted to hospital on 19 March following a serious act of self-harm. Although he was monitored under suicide and self-harm prevention procedures (known as ACCT) after this, I am concerned that the ACCT was closed prematurely and that staff gave too much weight to Mr McGuire's assurances that he had no suicidal intentions and insufficient weight to his risk factors, which remained unchanged.

I am also concerned that, despite Mr McGuire's history of mental ill health, healthcare staff were only involved in one of the ACCT reviews and that he did not have a mental health assessment before the ACCT was closed. I am very concerned that the mental health team discharged Mr McGuire from their caseload without assessing him in person even though he had been sectioned under the Mental Health Act only a few months earlier.

I also have serious concerns about the way staff at Birmingham conducted unlock and roll checks. When Mr McGuire was found on the morning of 24 April, he had clearly been dead for some time and there is no evidence that any member of staff had checked on his wellbeing for at least 12 hours. My office raised similar concerns in our report on the investigation of another self-inflicted death at the prison some six weeks before Mr McGuire's.

Staff also failed to use an emergency code when they found Mr McGuire unresponsive. Although this did not affect the outcome for Mr McGuire, it could make a critical difference in other cases.

Sue McAllister CB
Prisons and Probation Ombudsman June 2019

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Summary

Events

1. In October 2014, Mr Marcus McGuire received a 48-month prison sentence for burglary. He was released on licence in November 2016. On 15 November 2017, he was remanded into custody at HMP Hewell after his licence was revoked and he was recalled to prison for aggressive behaviour and drug use at an in-patient mental health facility. He was transferred to HMP Oakwood and, after assaulting staff, transferred again to HMP Birmingham on 1 February 2018.

2. On 19 March, Mr McGuire cut his wrists. Staff started suicide and self-harm procedures, known as ACCT, immediately. He was admitted to hospital on the same day and remained there for three days as he required surgery. On 5 April, staff stopped ACCT procedures after Mr McGuire consistently said that he had no further thoughts of suicide and self-harm.

3. At around 4.30pm on 23 April, staff locked Mr McGuire in his cell for the night. A night support officer signed to say he had completed roll checks between 9pm-10pm on 23 April and 6.00am on 24 April.

4. At about 8.45am on 24 April, a prison officer went to collect Mr McGuire for a medical appointment. She was unable to open his cell door or get a verbal response from him and summoned help. Another PCO forced the door open and found Mr McGuire unresponsive on the floor with a ligature round his neck. Rigor mortis had set in, so resuscitation was not attempted as Mr McGuire had clearly been dead for some time.

Findings

Management of ACCT

5. Staff monitored Mr McGuire under ACCT procedures following his serious act of self-harm on 19 March but there were occasions when staff did not interact with him in line with the frequency of observation required.

6. We consider that ACCT monitoring was ended prematurely on 5 April. We are concerned that staff gave too much weight to Mr McGuire's assurances that he did not have suicidal intentions and insufficient weight to his risk factors (which had remained unchanged) and his unresolved mental health issues.

7. Although the ACCT was closed on 5 April, the NOMIS case management system was not updated until 16 April and the post-closure interview was only documented on G4S's own case management system (which meant it was not accessible to healthcare staff).

Emergency response

8. The prison officer who found Mr McGuire unresponsive in his cell asked for a member of healthcare staff to attend immediately but did not radio an emergency code. As a result, there was a two-minute delay before an emergency code was radioed by another officer and ambulance was called. Although this did not

affect the outcome in Mr McGuire's case as he had clearly been dead for some time, it could make the difference between life and death in other circumstances.

Roll checks and unlock

9. The night support officer on Mr McGuire's wing did not conduct a handover with the day staff on the morning of 24 April, did not update the wing occurrence book and left the wing before the day shift officers arrived.

10. There is no evidence that any member of staff conducted a roll check on Mr McGuire's landing or checked on his wellbeing before he was found in his cell at 8.45am on the morning of 24 April.

Clinical care

11. The reception health screen Mr McGuire received at Birmingham did not identify his mental health and substance misuse issues.

12. We are very concerned that the mental health team at Birmingham discharged Mr McGuire from their caseload without assessing him in person.

13. Given the concerns staff had about Mr McGuire's apparently paranoid behaviour, we are concerned that mental health staff were not asked to attend ACCT reviews before the ACCT was closed.

14. We are also concerned that when a mental health nurse saw Mr McGuire on 13 April she did not read the ACCT paperwork.

Recommendations

15. At the time of Mr McGuire's death, Birmingham was being run by G4S. As the prison is now managed by HM Prison and Probation Service (HMPPS), we have made our recommendations to the HMPPS Governor.

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that:
    - A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.
    - All known risk factors are considered when determining the level of risk of suicide and self-harm.
    - Staff must follow the required frequency of observations and conversations stated.
    - An ACCT caremap, with identifiable actions aimed at reducing a prisoner's risk should be completed.
    - All information relevant to the management of an ACCT document should be documented in NOMIS and the ACCT document.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that

they use the appropriate emergency medical code to communicate the nature of the emergency effectively.

- The Governor should ensure that all prison staff are aware of the correct procedures at roll checks and that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner.
- The Governor should initiate an investigation into the night support officer's actions during his shift on 23/24 April 2018.
- The Head of Healthcare should ensure that PPO investigators are provided with complete computerised healthcare records to enable effective investigations.
- The Governor and the Head of Healthcare should ensure there is continuity of mental health provision for those prisoners transferred from another establishment and that all mental health referrals are followed up in a timely manner, to ensure prisoners receive effective care.
- The Governor and Head of Healthcare should ensure that staff explore why prisoners have not collected their mental health medication.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

17. The investigator visited Birmingham on 8 May 2018. She obtained copies of some relevant extracts from Mr McGuire's prison and medical records and returned to Birmingham in June and October.

18. She interviewed 11 members of staff and two prisoners between May and December.

19. NHS England commissioned a clinical reviewer to provide a review Mr McGuire's clinical care at the prison. He joined the investigator for three of the interviews. However, after our initial report was issued, it became clear that PPO had not been supplied with all the information needed to investigate all the clinical issues affecting Mr McGuire's care.

20. We informed HM Senior Coroner for Birmingham and Solihull districts of the investigation. She gave us the results of the post-mortem investigation. We have sent her a copy of this report.

21. The investigator contacted Mr McGuire's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr McGuire's father said he did not understand why his son had ended up at Birmingham as he had been in a mental health centre a few weeks before his imprisonment. His father said that his son would not have killed himself if he had known that he was due to be released shortly.

22. After receiving the initial report, the solicitor representing Mr McGuire's family raised several points concerning factual accuracy. Some amendments have been made to this report as a result. We have responded to Mr McGuire's family's comments about the investigative process by means of separate correspondence. HMPPS did not identify any factual inaccuracies.

Background Information

HMP Birmingham

23. HMP Birmingham prison is a local prison covering the courts of the West Midlands. At the time of Mr McGuire's death, it held up to 1,450 men and was managed by G4S Care and Justice Services, who had run it since 2011. On 20 August 2018, the Ministry of Justice placed HMP Birmingham under the control of HMPPS following concerns about conditions, safety and management issues.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Birmingham was from 30 July - 9 August 2018. HM Chief Inspector invoked the Urgent Notification process on 16 August, informing the Secretary of State for Justice that there were significant concerns about the conditions and treatment of prisoners at the prison. Inspectors reported that conditions had deteriorated dramatically since the last inspection in February 2017, and that the prison had failed all four healthy prison tests with respect to safety, respect, purposeful activity, and rehabilitation and release planning.

25. 71% of prisoners said they felt unsafe at some point during their stay at Birmingham and although levels of self-harm were lower than at similar prisons, there was evidence that such incidents were being under reported. Inspectors found disturbingly high levels of violence .and a serious failure to tackle safety issues. Case management of prisoners at risk of suicide and self-harm was poor, the response to previous PPO recommendations after deaths in custody investigations had not been sustained, and prisoners at risk of self-harm did not feel well cared for. Many staff lacked both confidence and competence in key prison skills. This was compounded by ineffective front-line management and leadership.

26. Healthcare and substance misuse services were reasonable though the rate of prisoners not attending medical appointments was very high. A well-integrated mental health team offered an appropriate range of support. Referrals were seen promptly and care planning was generally good.

Independent Monitoring Board

27. 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 June 2018, the IMB reported that HMPPS had served two Notices to Improve on Birmingham. One focused on the correct completion of ACCT documents as many ACCT documents had contained incomplete information.

Previous deaths at HMP Birmingham

28. Mr McGuire's death was the 25th at Birmingham since April 2015, and the fifth self-inflicted death in that time.

29. The PPO investigated the self-inflicted death of a prisoner who died almost seven weeks before Mr McGuire. There are similarities between the deaths in

that staff did not effectively investigate why Mr McGuire had harmed himself; healthcare staff were not involved in the ACCT process, which was closed with little having been done to identify or mitigate the prisoner's risk to himself; and both prisoners had clearly been dead for some time when they were found, giving rise to concerns about how roll checks and unlocks had been conducted.

Assessment, Care in Custody and Teamwork

30. ACCT is the care planning system HM Prison and Probation 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. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

31. On 30 October 2014, Mr McGuire was sentenced to 48 months imprisonment for burglary. It was not his first time in prison custody. Staff supported him under ACCT in December 2015/January 2016 and again in June to August 2016.

32. In August 2016, at HMP The Mount, Mr McGuire appeared to be experiencing psychosis. He was assessed by a psychiatrist who diagnosed several possible causes: acute schizophrenia, drug induced psychosis, organic cause, paranoid personality disorder, delusional disorder. He responded to anti-psychotic medication.

33. On 11 November 2016, Mr McGuire was released on licence from HMP Peterborough His licence requirements were to comply with Probation Service supervision requirements, to attend any medical appointments and co-operate with treatment.

34. On 19 October 2017, following reports to the police that he was behaving in a bizarre and intimidating manner towards staff and residents in the B&B hotel where he was living, Mr McGuire was sectioned under the Mental Health Act and admitted as an inpatient to a secure psychiatric unit. He was discharged from the unit on 6 November because of his poor behaviour, caused by continued drug use, and his refusal of drug tests.

HMP Hewell

35. As a result, Mr McGuire's licence was revoked and he was recalled to prison on 14 November. The licence recall report highlighted that Mr McGuire had undiagnosed mental health issues which manifested itself in extreme paranoia, and meant that he could be vulnerable in prison to bullying.

36. On 15 November, Mr McGuire was transferred to HMP Hewell. His Person Escort Record (PER) risk indicator form completed at a police station said that he had had suicidal thoughts on 27 September. Mr McGuire was referred to the substance misuse and mental health team at Hewell.

37. On 5 December, Mr McGuire complained to a prison officer that he had told staff on his houseblock that he felt like killing himself. A custodial manager discussed with Mr McGuire whether he was having suicidal thoughts. He said he was not but wanted more information about his licence recall.

HMP Oakwood

38. On 11 December 2017, Mr McGuire was transferred to HMP Oakwood. In reception he told an officer that he was happy to be there and did not have thoughts of self-harm. He was prescribed mirtazapine, an anti-depressant, and quetiapine, an anti-psychotic medication which has a calming effect.

39. On 29 December, a nurse tried to take a blood sample to monitor the effect of his anti-psychotic medication. Mr McGuire became hostile and expressed paranoid ideas that staff would infect him with HIV using a needle. Later that day he was accepted on to the mental health team caseload.

40. On 1 January 2018, Mr McGuire was found with a suspected illicit substance. He was charged under prison disciplinary rules and downgraded to the basic regime, the lowest level of the Incentives and Earned Privileges (IEP) system. On 4 January, Mr McGuire was relocated to the Care and Separation Unit (CSU, also known as the Segregation Unit) after beginning a "dirty protest" (smearing faeces on the walls of his cell). He said he did it because he did not want a cellmate. Staff considered that he had mental health issues. On 8 January, while collecting his evening meal he threatened to punch a member of staff for "stitching him up" and threw his plate of food. Force was used to return him to his cell. On 13 January, a mental health appointment was made for 18 January. On 17 January, he stopped his dirty protest and was moved to another cell in the CSU.

41. A nurse re-arranged a number of mental health assessments on 18 and 24 to 26 January, but they did not take place. On 28 January, Mr McGuire assaulted prison staff and said that he needed a mental health referral because his medication had been stopped and he felt his only options were assaults or dirty protests. CSU staff told another nurse that they were not happy unlocking him as they did not feel safe and as a result, she was unable to give Mr McGuire his medication.

42. Mr McGuire remained in the CSU until 1 February when he was transferred to HMP Birmingham.

HMP Birmingham

43. When he arrived at Birmingham, Mr McGuire was interviewed by a PCO who assessed him as not suitable for sharing a cell. He told her that he did not have any thoughts of suicide or self-harm and had never harmed himself. She described his demeanour as cheerful.

44. He was also seen by a dual diagnosis (mental health and substance misuse) nurse for an initial health assessment. She noted that he engaged with her, had undergone detoxification and did not show any overt signs of psychosis or suicidal thoughts. She wrote in his clinical record that he had no drug, alcohol or mental health issues. Mr McGuire was allocated cell D1-15 on D wing, in the first night centre.

45. On 2 February, a Drugs and Alcohol Recovery Team (DART) worker discussed the dangers of using illicit substances with Mr McGuire. Mr McGuire signed a form to confirm that he understood. He did not have any further contact with the DART.

46. On 5 February, an offender supervisor wrote in Mr McGuire's case notes that he had spoken to Mr McGuire through his cell door but he was unable to complete the interview due to Mr McGuire's poor mental health. Staff told him it had taken three officers to get Mr McGuire into his cell. The offender supervisor returned on 7 February, but Mr McGuire told him through his cell door that he would resist any attempt to move him from his cell. (The investigator requested an interview with the offender supervisor but the prison was unable to identify a member of staff with his name.)

47. On 19 February, one of the nurses from Oakwood contacted Birmingham's mental health team and asked them to assess Mr McGuire because they had not completed a mental health assessment at Oakwood as Mr McGuire had been transferred to Birmingham around the time it was due.

48. On 26 February, a nurse wrote in Mr McGuire's clinical record that Mr McGuire had seen the dual diagnosis nurse on his arrival at Birmingham and she had considered that he was currently stable, so they would see if he continued to remain settled. Mr McGuire was discharged from the mental health care team caseload.

49. On 18 March, Mr McGuire left his cell at lunchtime and tried to climb over the landing railings and onto the safety netting. Staff restrained and handcuffed him before returning him back to his cell. A nurse wrote in his clinical record that Mr McGuire did not complain of injury and no injuries were seen. When the evening meal was being served, staff were about to unlock Mr McGuire's cell when he threatened them from behind his cell door.

ACCT Document

50. On 19 March at 4.20am, Mr McGuire told a night officer that he had cut his wrist because he was feeling depressed. She radioed for healthcare assistance and immediately began ACCT monitoring procedures. A nurse examined Mr McGuire. She noted that he had made a deep, gaping cut to his left wrist with a razor blade, which had bled heavily and needed hospital treatment. He had also made a smaller cut to his right wrist. He was taken to hospital by taxi with a staff escort and was admitted. An ACCT document was opened before he left the prison. His partner was informed that he was in hospital.

51. In hospital Mr McGuire was attached to one of the officers by an escort chain, which has a single handcuff at either end and a length of metal chain in the middle. He did not take his anti-depressant medication on 20 March. On 21 March, at 9.00pm, Mr McGuire asked the escort officers if they would turn a blind eye while he choked himself to death with the chain. They refused, and asked him why he wanted to end his life. Mr McGuire said that he was depressed, had nothing to live for and it did not matter whether he had a family or a partner. He did not take his medication. On 22 March, a surgeon operated on Mr McGuire's left wrist. He was discharged from the hospital with pain relief and antibiotics and arrived back at the prison in the evening. A nurse and a GP reviewed him on his return.

52. On 23 March, a trained assessor met with Mr McGuire for an ACCT assessment. Mr McGuire said he had harmed himself when he was feeling very low and he was "not thinking straight". He insisted that he had no intention of killing himself, and said that it was the worst act of self-harm that he had committed and he would not do it again. It was recorded that Mr McGuire appeared flat at times during the assessment but he said that his partner was supportive. He also said that, although he had received documentation about the reasons for his licence recall, he was not sure of his release date, and hoped he would be able to reclaim some of the days back and be released from prison early.

53. A case review took place immediately after the assessment. A senior manager, the ACCT assessor, a First Line Manager (FLM) and Mr McGuire attended. No healthcare staff were invited to take part. Mr McGuire repeated that he would not harm himself again. Those present took his mentioning his release as a positive sign that he was thinking about the future. They assessed Mr McGuire's risk of harm to himself as low and the current likelihood of further risk behaviours as low. They did not complete a caremap (a plan to identify measures aimed at reducing a prisoner's vulnerability to self-harm). There is no evidence that anyone looked into Mr McGuire's release date to clarify it for him. The ACCT document remained open and the next case review was scheduled for 26 March. The frequency of observation was set at twice an hour.

54. On 26 March, the second case review was attended by two FLM's, a nurse and Mr McGuire. One of the FLM's wrote in the summary of the review that Mr McGuire appeared agitated and reluctant to engage at first. He made comments about staff and his food being poisoned which sounded paranoid. She initiated a caremap. She identified two issues: that his presentation was bizarre and his cell sharing risk assessment should be reviewed as he was potentially high risk. They decided that his level of risk was unchanged and the frequency of observations should remain the same.

55. After the review, she emailed Birmingham's mental health team with her concerns about Mr McGuire. She wrote that he would be an extremely challenging individual to share a cell with and it would be beneficial to have mental health team input in completing a cell sharing risk review. Although Mr McGuire should have been observed at least twice an hour, there were no written entries in his ACCT plan between 1.10pm and 5.10pm on 27 March.

56. On 28 March, Mr McGuire wanted to help himself to lunch rather than have it served to him. When he was told this was not possible, he said that staff were "doing something" to his food and he threw it on the floor and attempted to jump on the safety netting. He was returned to his cell without force being used. During the evening meal, he again was unhappy that he could not take his own food and threw it down the stairs before being taken back to his cell. An officer told him his behaviour was unacceptable but Mr McGuire said that his food was being tampered with.

57. On the same day, the FLM who attended the first ACCT case review emailed a mental health team administrator to follow up the female FLM's referral. He asked how long it would take before Mr McGuire was seen. An appointment was arranged for 4 April.

58. On 29 March, there were no written entries in the daily support and supervision record of Mr McGuire's ACCT plan between 8.30am and 10.30am and 1.36pm and 3.00pm.

59. An ACCT case review took place on 30 March. The FLM who was present at the first review, another manager and Mr McGuire attended. They noted that Mr McGuire engaged well and had no current thoughts of self-harm. His cell sharing risk assessment had been reviewed, a caremap action point, and he was assessed not suitable for sharing a cell. As he had not seen a mental health nurse, they kept the frequency of observation at twice an hour.

60. On 3 April, Mr McGuire asked for three 50mg anti-psychotic tablets rather than one of 150mg. He said that the single larger dose tablet gave him a headache. Staff did not observe him between 10.20am and 12.15pm, when an officer wrote a brief observation that Mr McGuire was standing by his bed. No further entries were made until 5.00pm. A mental health nurse attempted to see Mr McGuire on 4 April, but was unable to do so because a shortage of custodial staff meant his cell could not be unlocked. Another appointment was made for 17 April.

61. On 5 April, the duty director chaired an ACCT review attended by the FLM who had been at the first review and Mr McGuire. No healthcare staff were invited to take part. Mr McGuire said he did not have mental health problems or any other issues. He said he did not need to be on an ACCT and being observed disturbed his sleep. The duty director updated the caremap, incorrectly, to record that that Mr McGuire had not attended his mental health appointment on 4 April. The decision was taken to close the ACCT document. However, his case records show the date of closure as 16 April. A post-closure interview was scheduled for 12 April.

62. On 12 April, Mr McGuire went to the medication hatch and told the nurse that staff were changing his medication which was giving him headaches and he wanted to see a doctor. The nurse asked him to make a GP appointment but he swore at her and became angrier. She wrote in his clinical record that she asked the officer who was supervising the queue to move Mr McGuire out of the way but the officer did not respond or intervene. Mr McGuire shouted at the nurse and punched the jug of water on the hatch ledge causing it to hit her and spill the water. An alert was recorded in his clinical record that healthcare staff should not see him alone.

63. On 13 April, a mental health nurse saw Mr McGuire. He told her that he had not asked to see anyone from the mental health team and that his mental health was stable, although he said he felt depressed. She found his manner guarded and paranoid but noted that his risk of self-harm was being managed on an open ACCT document and an appointment for a mental health assessment with the primary mental health team had been arranged for 17 April. When interviewed, she said she did not realise that the ACCT had been closed and that she did not read ACCT paperwork before seeing prisoners.

64. Also on 13 April, one of the FLM's who had attended the second case review completed Mr McGuire's post-closure ACCT review. The ACCT plan and the information about the post-closure review was documented in the G4S case management system and not the Prison Service NOMIS case management system. This meant that only staff employed by G4S could access it. The post-closure interview form in the ACCT document itself was blank. Mr McGuire did not raise any concerns and the FLM decided that the ACCT should remain closed. Mr McGuire did not attend his mental health appointment on 17 April. His clinical record indicated that he refused the appointment. A GP appointment was arranged for 24 April.

Events of 23 and 24 April

65. Mr A, one of the prisoners in the cell D1-14 next door to Mr McGuire's cell, told the investigator that Mr McGuire began shouting out of his cell door from 7.00 or

8.00pm on 23 April. He said that he could hear Mr McGuire shouting to the officers, “Please come and speak to me.” Mr A said that the officers did talk to Mr McGuire at first, although after an hour or two Mr McGuire asked why they were ignoring him. He said that Mr McGuire was in distress, crying and sounding agitated.

66. He said that he tried to talk to Mr McGuire through the cell wall and sometimes he would respond for a couple of minutes then say nothing for half an hour. He said that he did not know why Mr McGuire was behaving like that as he was not making much sense. He said that he rang his cell bell a couple of times to ask about Mr McGuire and the officer said, “He’s ok, don’t worry about him.” He said that between 2.45 and 3.00am, Mr McGuire became quiet. The prisoner said he remembered the time because he was watching the BBC news channel, which was showing the time.

67. Mr B, a prisoner who shared cell D1-14 with Mr A, told the investigator that he woke up for 5-10 minutes between 2.30am and 3.00am and heard someone saying, “Help”. It was not a loud call and he went back to sleep. In the morning, Mr A asked Mr B if he had heard a noise on the wing the night before and Mr B told him what he had heard.

68. The night support officer who was on duty on D wing the night of 23/24 April said it had been a quiet night. He said he thought he had spoken to Mr McGuire when he came on duty. He said that Mr McGuire told him that he was making up a place to sleep on the cell floor. The night support officer had seen him do that before so it did not strike him as unusual. He said he thought he had seen Mr McGuire in the morning as he recalled someone sleeping on the floor and Mr McGuire was the only person on D1 landing who did that. He said he had left the wing unstaffed in the morning – he could not remember why - but said it would not have been for more than five minutes. He said that when he returned to the wing, someone had locked the gates, which he took to mean that they were happy to take over duty.

69. On 24 April, the first officer on duty on D wing told the investigator that she found the gate to the wing open, the night support officer was not present, and she said that the wing had not been counted and nothing was written in the observation book. She said that she locked the gate, counted D3 and D4 landings and supervised the wing cleaners.

70. The investigator was unable to establish whether any member of staff did a roll count on Mr McGuire’s landing (D1). At about 8.00am, officers unlocked the cells of those prisoners who were going to work or education. Mr McGuire’s cell was not unlocked.

71. Mr A, the prisoner in the cell next to Mr McGuire’s, told the investigator that when he was unlocked for work at about 8.00am, he left his cell and looked into Mr McGuire’s cell through the observation panel as he had been concerned about his shouting the night before. He said that he saw Mr McGuire slumped along the side of his bed hanging from a ligature which he thought was a green sheet. He described Mr McGuire’s body as being in an L-shape, as if he was sitting. He said that he ran to the staff office, told an officer what he had seen and then the officer locked him back in his cell.

An officer arrived on D wing at about 8.40am to escort Mr McGuire to a GP appointment. She unlocked his cell but could not push his door open. She looked through the observation panel but could not see him in his cell. Another officer looked in and saw Mr McGuire's legs on the floor. She was unable to open his cell door.

72. The prison's communications room incident log shows that an officer working on that landing radioed for immediate healthcare assistance at 8.43am. The officer who had come to collect Mr McGuire radioed an emergency code blue (an emergency code indicating that the prisoner is not breathing) message at 8.45am and an ambulance was called immediately.

73. PCO J, an officer who worked on D wing, told the investigator that he was on D3 or D4 landing when he heard a radio message for healthcare staff to attend D1. He ran downstairs and saw the two female officers who were unable to get into Mr McGuire's cell or get a response from him. He looked into the cell and could see Mr McGuire's legs but could not see his whole body as he was lying behind the cell door. PCO J barged against the cell door several times until it opened slightly and he managed to squeeze into the cell. He saw Mr McGuire had a ligature around his neck that appeared to be an elasticated surgical stocking tied tightly around his neck. It was not attached to anything. PCO J cut it with his ligature-cutting tool that all officers carry.

74. Two nurses arrived at the cell. They saw Mr McGuire lying on his back. His arms were rigid and his face was purple and bloated. His body showed no signs of life. His body was stiff, pupils fixed and he was not breathing. They decided not to begin CPR as the presentation of Mr McGuire's body was incompatible with life. Ambulance staff arrived and at 9.00am, confirmed that Mr McGuire had died.

Contact with Mr McGuire's family

75. The Director and a family liaison officer arrived at Mr McGuire's partner's home at 11.00am but she was not at home. They returned at 2.00pm and broke the news of Mr McGuire's death.

76. The prison contributed to the cost of the funeral in line with national guidance, which was accepted by his family.

Support for prisoners and staff

77. After Mr McGuire's death, a senior 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.

78. The prison posted notices informing other prisoners of Mr McGuire's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr McGuire's death.

Post-mortem report

79. The post-mortem report gave Mr McGuire's cause of death as constriction by a ligature around his neck. It described the ligature as an anti-embolism stocking

(an elasticated surgical stocking designed to prevent blood clots). There were traces of his prescribed anti-depressant in his blood and no traces of illegal substances.

Findings

Management of ACCT

80. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm and suicidal ideation, mental health problems, licence recall and following each transfer between prisons. All these risk factors applied to Mr McGuire.

81. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in 2014, we identified that suicide and self-harm assessments often place too much weight on staff's perception of the prisoner and do not consider all relevant information. The way a prisoner appears and what they say can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

82. We do not consider that the ACCT assessment and reviews took sufficient account of Mr McGuire's risk factors, which included being recalled, a history of mental ill health and a very recent act of serious self-harm. He had been hospitalised on 19 March after inflicting a deep wound on himself which he described as the worst self-harm he had ever done, and on 21 March he had told the officers escorting him in hospital that he had nothing to live for and asked if they would look the other way while he strangled himself with the escort chain.

83. In these circumstances we find it difficult to understand why staff assessed Mr McGuire's risk to himself as 'low' at the first ACCT review on 23 March.

84. PSI 64/2011 states that healthcare staff should attend the first ACCT review. A healthcare professional was only present for the second of the four ACCT reviews and none of the staff who took part and were interviewed could explain satisfactorily why healthcare staff were not invited. Healthcare input was particularly important in Mr McGuire's case because he had a history of mental health issues (including having recently been sectioned under the Mental Health Act) and staff thought his behaviour was bizarre and paranoid.

85. We are also concerned that a caremap was not drawn up until 26 March, and was not sufficiently detailed. PSI 64/2011 says that caremap actions should be detailed and aimed at reducing the prisoner's risk. Although the caremap appropriately identified concerns about Mr McGuire's bizarre and paranoid behaviour, this was phrased in terms of his cell sharing risk assessment (that is, his risk to others) rather than his risk to himself. Although Mr McGuire's upcoming release was seen as a protective factor, the caremap did not include an action to clarify the date of his release for him (which he had been asking about), and there was no mention of his relationship with his partner (which he had also said was an important protective factor).

86. PSI 64/2011 states that "staff must follow the level of observations and conversations as stated in 'required frequency of conversations and

observations' box on the front cover of the ACCT. These must be recorded immediately or as soon as practicable thereafter". On several days including 28, 29, 30 March and 3 April, although Mr McGuire should have been monitored at least twice an hour, there was no evidence that the required observations had taken place. This is unacceptable. Observation arrangements are put in place to ensure that the person at risk of self-harm or suicide is safe and has not harmed themselves. They are not optional.

87. We are concerned that the ACCT was closed prematurely before Mr McGuire was seen by a member of the mental health team. The duty director who decided to close the ACCT, wrongly wrote in the caremap that Mr McGuire did not attend his appointment, which suggested that Mr McGuire had made that choice when, in fact, a lack of staffing had meant that the appointment could not go ahead.

88. We consider that, in deciding to close the ACCT, staff placed too much weight on Mr McGuire's assertions that he would not harm himself and not enough weight on his risk factors (which remained unchanged) or his behaviour which suggested he required mental health support.

89. The ACCT document was closed on 5 April, but Mr McGuire's case records were not updated to reflect this. This led to the mental health nurse believing, erroneously, that Mr McGuire was receiving support through the ACCT process when in fact he was receiving nothing.

90. As the prison is now managed in the public sector, we make the following recommendations to the HMPPS Governor:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that:

- **A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.**
- **All known risk factors are considered when determining the level of risk of suicide and self-harm.**
- **Staff must follow the required frequency observations and conversations stated**
- **An ACCT caremap, with identifiable actions aimed at reducing a prisoner's risk should be completed in every case.**
- **All information about the management of an ACCT document should be documented in NOMIS and the ACCT document.**

Emergency response

91. Mr A's account that he saw Mr McGuire slumped on his bed with a ligature round his neck at about 8.00am and that he told an officer, is very different from staff's account that Mr McGuire was found by an officer at about 8.40am and that he was on the floor by the door and could not be seen through the observation panel. There is no CCTV on the wing so we have not been able to confirm or disprove Mr A's account, although we note that the post-mortem report found that Mr

McGuire had used a surgical stocking as a ligature and not the green bedsheet which Mr A said he saw.

92. PSI 03/2013, on medical emergency response codes, requires prisons to have a protocol on communicating the nature of a medical emergency and the type of equipment to take to the incident, and to ensure that there are no delays in calling an ambulance. It states that if a medical emergency code is radioed, an ambulance must be called immediately.

93. Birmingham's local policy mirrors PSI 03/2013, and requires that staff should radio a code blue emergency when a prisoner has difficulty breathing or is unconscious and that the control room should call an emergency ambulance automatically.

94. When staff saw Mr McGuire unresponsive in his cell, an officer radioed that healthcare should attend D1 landing immediately but he did not give any indication of the nature of the incident. He should have radioed a code blue emergency when he saw Mr McGuire was unresponsive. It appears that the two officers tried to gain access to the cell before calling a code blue over the radio. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively

Roll check and unlock procedures

95. By the time Mr McGuire was found at 8.43am, rigor mortis was present which suggests he had been dead for at least four hours. Mr A and Mr B's accounts suggest that he was alive until at least 3.00am, but we have been unable to confirm their accuracy or to determine when Mr McGuire was last seen by staff.

Roll check

96. The night support officer said that he spoke to Mr McGuire on the evening of 23 April, and thought he saw him asleep on the floor on the morning of 24 April when he was doing the roll check. Although he did not record that he had done the morning roll check in the wing observation book, the night support officer told the investigator that he had completed the roll check between 5.00 and 6am and then informed the night orderly officer that he had done so.

97. A roll check is primarily a security check to count prisoners to ensure that they are present in their cells, but it is also an opportunity for any concerns about prisoners' safety to be identified and addressed.

98. In the absence of CCTV, we have been unable to verify the night support officer's account of when he carried out the roll check. However, it seems very likely that Mr McGuire was already dead by 5.00am. We know that the officers who found him dead could not see him through the observation panel, which means that it would not have been possible for the night support officer to have seen him either.

99. If the night support officer could not see Mr McGuire when he did the roll check, he could not be sure that he was in his cell and should not have confirmed to the night orderly officer that all the prisoners were in their cells. This is a cause for serious concern from both a security and a safety perspective.

100. We are also concerned that the night support officer had left the wing before the day shift officers arrived and did not complete a handover in person or in writing.

Unlock

101. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prisoner Officer Entry Level Training (POELT) manual says:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

102. Prison Service Instruction 75/2011, *Residential Services*, says:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable. The specification requires there to be positive engagement between staff and prisoners and for prisoners to be supported and their daily needs met, and this clearly requires some form of interaction or conversation to take place at times during the day.
>
> "The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. For example, if a prisoner is expected to leave their cell for an activity shortly after being unlocked, then it will be sufficient for there to be a check on any prisoner who does not do so. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

103. As Mr McGuire was not going to work or education, he was not unlocked on the morning of 24 April and he was only found when an officer went to collect him for a GP appointment. We are concerned that no one checked on his wellbeing that morning and that, if he had not had an appointment, he might not have been found until much later.

104. We make the following recommendations:

The Governor should ensure that all prison staff are aware of the correct procedures at roll checks and that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner.

The Governor should initiate an investigation into the night support officer's actions during his shift on 23/24 April 2018.

Clinical care

105. In our initial report, the clinical reviewer concluded that the care Mr McGuire received from primary healthcare staff was of a good standard and equivalent to the care he would have received in the community. However, he concluded that some elements of Mr McGuire's mental health care were not wholly equivalent to the care he could have expected to receive in the community. We agreed. After the initial report was issued, Mr McGuire's family's solicitor raised concerns that the report had not explored inconsistencies in the administering of Mr McGuire's medication over a period of 13 days before his death. We were disappointed to learn that neither PPO nor the clinical reviewer were provided with Mr McGuire's complete medical record. We view this as a serious omission as it has impacted on the effectiveness of our investigation.

106. We are concerned that the reception health screen Mr McGuire received at Birmingham did not identify his mental health and substance misuse issues. This is a particular cause for concern because, three months earlier, he had been an in-patient at a secure psychiatric unit and it was thought that his mental health issues may have been caused by his drug taking.

107. We also share the clinical reviewer's concern that there were further missed opportunities to engage Mr McGuire with mental health services at Birmingham over a period of three months.

108. We are very concerned that, when they were told by Oakwood on 19 February that Mr McGuire had a mental health assessment outstanding, the mental health team at Birmingham discharged Mr McGuire from their caseload without assessing him in person on the grounds that he was currently stable. Although the dual diagnosis nurse had seen Mr McGuire in reception on 1 February, she had not had access to his medical history at the time and had not been aware that he had been sectioned under the Mental Health Act three months earlier. In addition, Mr McGuire's behaviour did not suggest that he was mentally stable – in the month before he transferred to Birmingham he had engaged in a dirty protest and assaulted staff and had been due to have a mental health assessment because of concerns about his mental health, and within days of his arrival at Birmingham there is a note in his records of concerns about his mental health. We consider that the mental health team should have assessed him, given his recent history, and that it was very poor practice not to have done so.

109. Given the concerns staff had about his apparently paranoid behaviour, we are also concerned that mental health staff were not asked to attend ACCT reviews before the ACCT was closed.

110. We are also concerned that when the mental health nurse saw Mr McGuire on 13 April she did not read the ACCT paperwork before she saw him and said that it was not her practice to do so before she saw prisoners. We consider that this is a significant error of judgement because it means that she may be unaware of important information when she undertakes an assessment.

111. From 11 April until his death, Mr McGuire refused or did not collect all of the medication he had been prescribed. It is troubling that the prison failed to investigate his repeated pattern of missed doses, especially when he had made a serious and deliberate attempt of self-harm less than a month before. We regret that we were unable to examine this aspect of his clinical care as thoroughly as we would have wished, due to a lack of timely information.

112. We make the following recommendations:

The Head of Healthcare should ensure that PPO investigators are provided with complete computerised healthcare records to enable effective investigations.

The Governor and the Head of Healthcare should ensure there is continuity of mental health provision for those prisoners transferred from another establishment and that all mental health referrals are followed up in a timely manner, to ensure prisoners receive effective care.

The Governor and Head of Healthcare should ensure that staff explore why prisoners have not collected their mental health medication.

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