Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nigel Sullivan a prisoner at HMP Hull on 16 October 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

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

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

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

On 16 October 2016, Mr Nigel Sullivan was found hanged and with his wrists cut in a disabled toilet at HMP Hull. He was 43 years old. I offer my condolences to Mr Sullivan's family and friends.

While staff identified some aspects of Mr Sullivan's risk of suicide and self-harm and took some steps to support him, I am concerned that other evident risks were ignored. As a result, suicide and self-harm procedures were not always applied when they ought to have been and, when they were, I consider that they were ended prematurely.

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 2018**

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Summary

Events

1. Mr Nigel Sullivan was remanded to custody in April 2016. He had a history of alcohol and drug misuse, had a previous history of self-harm and had last been in custody 24 years previously.

2. He was identified as having Nazi and racist sympathies by distinctive tattoos on his body and remained on the induction wing until, after a comprehensive assessment, he was accepted on to a substance misuse recovery wing in June.

3. On 5 September, Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm support procedures were initiated. Mr Sullivan disclosed to a member of staff that he was having suicidal thoughts because his relationship with his wife had broken down and she was not answering his telephone calls. He said he could not give assurances that he would not harm himself. The ACCT was closed the next day after Mr Sullivan described his situation as a 'misunderstanding'.

4. On 29 September, court staff completed a suicide and self-harm warning form after Mr Sullivan told his solicitor that he would kill himself if found guilty. His wife telephoned Hull and told staff that her husband intended to harm himself and would try to convince staff that he was not at risk. Hull did not open an ACCT.

5. After Mr Sullivan was sentenced to 13 years imprisonment, on 3 October, an ACCT was opened. It was closed a week later after Mr Sullivan assured staff at a case review that he did not have any suicidal thoughts.

6. On 16 October, Mr Sullivan's wife told him in a telephone call that she wanted to divorce him. An officer found Mr Sullivan hanging about two hours later in a disabled toilet. Staff and paramedics tried to resuscitate him but, at 5.24pm, it was confirmed that he had died.

Findings

7. Mr Sullivan had a history of self-harm, suicide and had experienced psychosis in the past, prior to his arrival at HMP Hull. Staff at Hull did not identify other risk factors for suicide and self-harm, such as his relationship breakdown and his conviction, and failed to manage the ACCT procedures effectively.

8. The two ACCT documents that were opened were closed too soon without fully resolving outstanding issues. Staff should have also have done more when they received information from two sources that Mr Sullivan was at risk of self-harm on 29 September when he was convicted; risk assessments did not consider all available information, a number of known risk factors for suicide and self-harm were present, and sufficient, practical measures were not taken to reduce his risk. Documentation setting out Mr Sullivan's risk was not located until after his death and there were breakdowns in communicating information between departments in the prison.

9. Mr Sullivan did not receive a mental health assessment despite requesting contact with the mental health team. The reasons why he was not formally referred to the metal health services were not clearly recorded. The opportunity for Mr Sullivan to be reviewed by healthcare following changes in his custodial status was also missed.

Recommendations

- The Governor should ensure staff identify, consider and record all known risk factors of a prisoner when determining the risk of suicide and self-harm.
- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
    - A multi-disciplinary case review is held within 24 hours of an ACCT plan being opened.
    - ACCT case managers use all available information to assess risk and caremap actions
    - ACCT documents should only be closed once all outstanding issues have been resolved.
    - The Governor should remind staff of the importance of sharing information and updating computerised records such as NOMIS whenever an event occurs, significant information is received, which suggests an increase a prisoners' risk.
    - The Governor and Head of HealthCare should ensure that prisoners being at risk of suicide and self-harm and/or with a history of mental health issues are referred urgently for a mental health assessment.
- The Governor and the Head of Healthcare should remind staff, in accordance with PSO 3050, healthcare staff should review a prisoners' wellbeing following a change in their custodial status.
- The Governor should ensure that all risk documentation relating to a prisoner should be readily available as necessary.

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The Investigation Process

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

11. The investigator visited Hull on 26 October 2016. She obtained copies of relevant extracts from Mr Sullivan's prison and medical records.

12. The investigator interviewed 11 members of staff and two prisoners in person or by telephone in November, January and February.

13. NHS England commissioned a clinical reviewer to review Mr Sullivan's clinical care at the prison. The clinical reviewer joined the investigator for joint interviews with two staff on 17 January 2017.

14. We informed HM Coroner for Hull of the investigation. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officer's contacted Mr Sullivan's wife, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr Sullivan's wife said that they were in the process of splitting up and he had telephoned her on the afternoon of his death and said he would always love her. She asked how her husband had been able to take his life on another wing to where he normally lived and asked for more details of the suicide monitoring measures he had previously been under.

Background Information

HMP Hull

16. HMP Hull is a medium security prison in Yorkshire that holds over 1000 remanded, convicted and sentenced adult men and young offenders. Healthcare is provided by City Healthcare Partnership, a not-for-profit social enterprise organisation. The Drug and Alcohol Rehabilitation Service is run by Lifeline.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Hull was an unannounced inspection in October 2014. Most vulnerable prisoners in the vulnerable prisoner wings felt safe although some prisoners on mixed units had received verbal abuse and threats from other prisoners. Levels of self-harm were lower than in similar prisons but documentation of prisoners at risk of suicide and self-harm showed that the care they received was variable. Inspectors found that initial ACCT assessments and records of observations were good but too many ACCTs were closed prematurely. Inspectors reported that health services were good, a good level of primary and secondary mental health care was available but support for prisoners with substance misuse issues who were not on the drug recovery wing was inconsistent.

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 2015, the IMB reported that Hull was an effectively-run prison that provided a safe and decent environment.

Previous deaths at HMP Hull

19. Mr Sullivan was the fifth prisoner to apparently take his own life at Hull since the beginning of 2015. There are some similarities with a previous death in that both prisoners had a close relationship breakdown and had asked for help with mental health and detoxification services. A prisoner who died in 2015 was referred for a mental health assessment on at least two occasions but was not seen by the mental health team.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. Mr Nigel Sullivan was remanded to HMP Hull on 12 April 2016 with his co-defendant, charged with conspiracy to rob. He told healthcare staff he had been in prison once before, in 1992, although his custodial records indicated it was his first time in prison. His previous convictions record contained warnings that he had cut his wrists in 2008, had thoughts of hanging in 2009, mental health psychosis in 2014 and had attempted an overdose in 2015.

22. Mr Sullivan's escort record noted the previous risks relating to self-harm by overdosing, cutting and thoughts of hanging. It also noted alcohol issues and recorded he had suffered with mental health problems in 2014.

23. At an initial reception health screen on 12 April, a nurse assessed Mr Sullivan using an alcohol audit screen of standard questions. The nurse did not note any physical symptoms but Mr Sullivan's responses to the questions indicated that he had an alcohol problem as he consumed 100 units a week. The nurse noted that Mr Sullivan had experienced psychosis in the past but he said he felt stable and was receiving support from his wife. He said he did not have thoughts of suicide or self-harm but disclosed that he tried to take an overdose a year ago. The nurse did not explore his disclosure further and did not refer him to mental health services. She referred Mr Sullivan to Lifeline, an organisation that runs a drugs and alcohol service at Hull.

24. Reception staff noticed that Mr Sullivan had numerous tattoos with racist and Nazi imagery on his head and body. He told them that he had been an active member of the National Front until recently. He told a prison manager who interviewed him in private, that he was against extreme Islam and Jews and that he had covered one tattoo with a plaster because he said it could cause him trouble if it was seen in prison. The prison manager advised Mr Sullivan not to voice his views in custody and to tell staff if a prisoner took offence to his tattoos, which he agreed to do. A racist alert warning was placed on his computerised prison record, the safer custody team were informed and the information was passed to the security team for evaluation. A Cell Sharing Risk Assessment (CSRA) was completed; he was assessed as high risk but could share with caution.

25. A clinician assessed Mr Sullivan for alcohol dependence syndrome. Mr Sullivan said that he had been drinking for 20 years, had stopped for three months but had resumed two weeks previously and had a 'serious binge' four days previously. Mr Sullivan said he felt okay and was not experiencing withdrawal. He was referred to the substance misuse programme and taken to the first night and induction wing.

26. On 13 April, Mr Sullivan was seen by a worker from Lifeline, for harm reduction advice and on 19 April for a more comprehensive assessment and to discuss a recovery plan. Mr Sullivan said he would like to move to the recovery unit to participate in group work and the Lifeline worker made a referral.

27. On 22 April, Mr Sullivan told a clinical support worker that he was suffering with anxiety, poor sleep and low mood. He said he did not have thoughts of suicide or self-harm but felt he would benefit from a mental health referral because he

managed in the community by using his wife's medication. The Lifeline worker referred him to mental health services and, that day. A nurse recorded in Mr Sullivan's clinical record that he had contact with Mr Sullivan by sending him a self-explanatory stress management booklet which covers different aspects of low-level mental health issues. The nurse did not see Mr Sullivan face to face but triaged him according to the referral in his clinical record. The nurse sent the booklet to Mr Sullivan using the internal mail system with a covering form on the back which prisoners can complete and return for an assessment if they still have concerns. There is no record that Mr Sullivan returned the form to the healthcare department and on 15 May he was discharged from its care.

28. On 11 May, the Lifeline worker told Mr Sullivan that the recovery unit had considered his application but had decided not to accept it due to his membership of the National Front. Mr Sullivan was upset that he had been rejected due to a 'past belief' and it was agreed that a member of staff from the group would discuss it with him. Mr Sullivan moved to the recovery wing on 13 June and participated in group sessions. Mr Sullivan's wife wrote to the Governor also expressing concern about her husband's safety; she was worried that his 'racial' tattoos might draw attention to him. A senior manager replied to her letter on 7 July and said that although the prison was concerned about the tattoos, Mr Sullivan said he was fine and that the main tattoo on his chest was not visible to others.

29. On 11 August, Mr Sullivan was charged with breaching prison discipline after an officer carrying out cell fabric checks, found a newspaper cutting on the cell wall with the slogan 'White Supremacy' of an actor performing a Nazi salute. A disciplinary hearing was held on 13 August. Mr Sullivan pleaded not guilty but the charge was proven and he was punished with 14 days stoppage of earnings at 50%, suspended for three months.

30. On 5 September, Mr Sullivan told the recovery wing group leader that he was feeling very low in mood and that he had many thoughts about suicide by hanging that weekend and was concerned that 'things may get worse'. He believed that his wife was involved in a relationship with a recently released prisoner who was living at their home. Since he had mentioned this in a telephone call to her he had been unable to contact her as she was not answering his calls. He told the recovery wing group leader that he was expecting his wife to end their marriage imminently and if this did materialise, he could not give any guarantees that he would not harm himself. He said he had overdosed twelve months previously by taking his wife's medication as a 'cry for help' but did not want to die.

31. The recovery wing group leader began ACCT suicide and self-harm prevention measures. A prison manager drew up an immediate action plan which included hourly observation and staff attempts to contact his wife. The next day, on 6 September, an officer, a trained ACCT assessor, interviewed Mr Sullivan. Mr Sullivan said he had wanted to take his life due to frustration but he felt alright as he had talked to his wife and had no thoughts of self-harm. A case review took place after the assessment, which was attended by a nurse, a supervising officer (SO) and Mr Sullivan. Mr Sullivan said he was feeling low in mood before but he had spoken to his wife who said that his children had misplaced her telephone. It

was agreed to close the ACCT as his problems were resolved. His upcoming court trial was not discussed.

32. On 29 September, Mr Sullivan's wife attended the court hearing where Mr Sullivan was found guilty. She telephoned Hull at 3.02pm and spoke to a safer custody administrator. She said her husband had told her that if he had to return to prison he would harm himself. She cautioned that he would try to convince staff that he was fine. The safer custody administrator passed the message to a SO, the officer in charge of Mr Sullivan's residential unit, and recorded the information in Mr Sullivan's computerised records. The SO told the investigator that he checked with the wing movements officer to see whether he had arrived from court periodically but Mr Sullivan did not return to the prison until 5.51pm and had not arrived back on the unit before he finished his shift at 6.30pm. He gave another SO, the evening manager, a verbal handover. He acknowledged to the investigator that he should have made a note in Mr Sullivan's computerised record and in the wing observation book. He did not inform reception and did not know whether the evening manager told reception or talked to Mr Sullivan about his wife's concerns. There is no written evidence that the evening manager did so and no ACCT was opened.

33. Mr Sullivan's clinical record showed that a nurse had asked Mr Sullivan about any thoughts of self-harm or suicide before he left Hull to attend court. However, no member of healthcare staff spoke to him on his return, contrary to Prison Service Order 3050 on significant life events affecting prisoner's health where a prisoner's wellbeing should be checked after a change in their custodial status.

34. On 29 September, on the last day of his trial, Mr Sullivan's solicitor informed court staff that he said he would commit suicide if found guilty. The court staff completed a suicide and self-harm warning form, which accompanied him on his return to Hull. An officer who was working in the reception area acknowledged receipt of the suicide and self-harm warning form. He ticked the box indicating he did not open an ACCT document.

35. On 3 October, Mr Sullivan returned to court to be sentenced. Court staff wrote in his person escort record that Hull had closed the court's suicide and self-harm warning form they had opened on 29 September. Hull was unable to provide the investigator with this form until November 2017.

36. Mr Sullivan received a sentence of 13 years for conspiracy to rob. An officer on reception opened an ACCT form on Mr Sullivan as he was concerned about the length of the sentence. Mr Sullivan insisted that he did not need an ACCT because he had accepted his sentence and said, 'it is what it is, boss.' His frequency of observation was set at 'one meaningful entry' in the morning, afternoon and evening.

37. That evening, Mr Sullivan asked to move wings. He said it was because he had been threatened by other prisoners, due to local publicity following his conviction. His request was considered by a prison manager and Mr Sullivan was moved to a landing for vulnerable prisoners in the induction wing the next day.

38. In an assessment interview with an officer on 4 October, Mr Sullivan said he had contemplated taking his life due to the length of his sentence, having no contact

with his wife and not being able to see his children. The officer did not explore this further or discuss what would prevent him from taking his life. Mr Sullivan asked the officer to contact his wife and to be referred to the mental health team. There is no evidence that the officer (who has since left the Prison Service) did either.

39. Mr Sullivan and the officer attended an ACCT case review immediately after the assessment interview, which was chaired by a SO. No healthcare staff attended. Mr Sullivan said the ACCT procedures would be a support and he would benefit from contact with the mental health team. The SO made a referral to the mental health team. Mr Sullivan said he wanted a job to keep himself occupied and he was feeling anxious because of his sentence and the effect this had on his family. The SO wrote in the caremap, a document where actions to reduce the risk of self-harm are recorded, that he should address his anxiety by settling into the unit routine by using befrienders and staff support and make a labour application. Mr Sullivan said he was maintaining good contact with his family and had no intention of harming himself. The SO assessed Mr Sullivan's risk of self-harm as low. He told the investigator this reflected the fact that that, although Mr Sullivan was low in mood, he did not express any intention to harm himself. He was not aware of the concerns expressed by Mr Sullivan's wife because he did not consult Mr Sullivan's computerised record. A further case review was set for 10 October when a member of the mental health team would be invited.

40. On 5 October, Mr Sullivan told an officer he was concerned that, due to his long sentence, he might be sent to HMP Full Sutton (a high security prison in Yorkshire). He did not want to go there as he thought his tattoos might upset Muslim prisoners. The officer advised Mr Sullivan to set out his concerns in a request to the Observation, Classification and Allocation (OCA) department.

41. On 10 October, a SO, a nurse and Mr Sullivan met for an ACCT case review. Mr Sullivan was preoccupied by his sentence and felt that he had been 'stitched up' at court due to his political views and intended to appeal against his conviction. He insisted that he had no current thoughts of suicide or self-harm. The SO and the nurse viewed this as Mr Sullivan looking towards the future. Neither was aware that Mrs Sullivan had raised concerns with Hull's safer custody team about her husband's intention to harm himself. The nurse told the investigator that he did not see evidence of mental health distress during the case review. In his view, Mr Sullivan had seemed credible and offered plausible excuses for his actions, he was stable in presentation, chatty with no suicidal ideation. The SO said he would not have acted any differently as an ACCT would have been opened following Mr Sullivan's wife's telephone call if the SO had thought it necessary. In light of Mr Sullivan insisting that he was not distressed and that he did not intend to harm himself, the nurse, the SO and Mr Sullivan agreed that the ACCT document should be closed. No post-closure review was scheduled.

42. Mr Sullivan's cellmate told the investigator that around 15 October, Mr Sullivan cut one of his wrists with a razor blade and blood was dripping onto the floor of their cell while he was writing a letter. Mr Sullivan said he was anxious about his wife not answering her telephone despite attempting to call her many times. He said that, because the cuts were not deep and he thought Mr Sullivan had

probably thrown the razor blade in the bin, he did not think it was of enough significance to tell staff.

16 October

43. Mr Sullivan attempted to call his wife 16 times between 9.04am and 11.34am without success. The induction wing (H wing), where Mr Sullivan lived, had a mixture of vulnerable and non-vulnerable prisoners who had to be kept separate mostly due to the nature of their offences. The vulnerable prisoners were located on H2 landing. As all of H Wing prisoners were not able to socialise together, arrangements were made for the prisoners on H2 landing, including Mr Sullivan, to go to the adjoining wing (G Wing) for association where all its prisoners were classed as vulnerable. At about 2.00pm, an officer escorted Mr Sullivan and the other H2 vulnerable prisoners to G Wing. No one had made a list of names of the prisoners that went to G Wing.

44. Mr Sullivan telephoned his wife at 2.20pm and they spoke for 15 minutes. She informed him that she intended to seek a divorce and that their relationship was over.

45. Closed circuit television showed Mr Sullivan entering a disabled toilet at 2.42pm with a bag. The toilets were unlocked so that prisoners from H Wing could use the facility without having to go into another prisoner's cell.

46. At about 4.00pm, the G Wing prisoners were locked in their cells and an officer collected H Wing prisoners from G Wing who had gathered by a gate connecting the two wings. No one kept a record of which prisoners had returned from G Wing. (Hull has now changed the function of both G and H Wings to have a mixed population, removing the need for H Wing vulnerable prisoners to go to G Wing.)

47. At about 4.20pm, an officer, the servery officer, noticed from his list that Mr Sullivan had not collected his evening meal and asked another officer where he was. His cellmate told the officer he had not seen Mr Sullivan return from G Wing. The officer informed a SO, who was in charge of G Wing, who in turn asked his staff to check all cells for Mr Sullivan.

48. At 4.52pm, an officer looked in the disabled toilet on G3 landing which was unlocked and saw Mr Sullivan hanging from a ligature attached to smoke alarm fixture on the ceiling. He had made some cuts to one of his arms. The officer radioed an emergency code red, (which indicates serious blood loss) at 4.52pm. He cut the ligature and supported Mr Sullivan's weight. A second officer arrived and helped the officer put Mr Sullivan in the recovery position. As they finished, a third officer arrived and asked whether they had attempted cardiopulmonary resuscitation (CPR) and they replied that they had not. One of the officers checked Mr Sullivan's pulse for signs of life and began CPR. Two nurses heard the code red, picked up emergency response bags from the treatment room and quickly made their way to the third floor. A nurse attached the defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) but it found no shockable heart rhythm.

49. At 5.05pm, paramedics arrived and continued to try to resuscitate Mr Sullivan. Paramedics confirmed he had died at 5.24pm.

50. Two letters addressed to Mr Sullivan's wife were found in the outgoing wing post box after his death, in which he wrote about his distress over his marital breakdown.

Contact with Mr Sullivan's family

51. Mr Sullivan had named his wife as his next of kin. At 10.40pm, a custodial manager, a senior manager and a family liaison officer broke the news of Mr Sullivan's death to his wife and children. The prison offered to contribute to the cost of Mr Sullivan's funeral in line with national policy.

Support for prisoners and staff

52. Managers debriefed the staff involved in the emergency response and offered support. Staff notified prisoners of Mr Sullivan's death, and offered them support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr Sullivan's death had affected them.

Post-mortem report

53. The post-mortem report showed that Mr Sullivan died as a result of hanging. Toxicology tests found no illicit substances in his bloodstream at the time of his death.

Findings

Assessment of risk of suicide and self-harm

54. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide or self-harm. Mr Sullivan arrived at Hull with some recognised risk factors for suicide and self-harm including a history of self-harm, alcohol misuse and a psychotic episode in 2014. When Mr Sullivan arrived, he told staff that he had no thoughts of suicide or self-harm and staff assessed that he was not at risk. We are satisfied that staff considered Mr Sullivan's risk and it was reasonable for them to conclude that he did not need to be monitored under ACCT procedures when he arrived in April.

55. However, by October, Mr Sullivan's risk had raised. He was convicted of the offence, which he did not expect, received a lengthy sentence, was worried that he would be moved to a high security prison where his tattoos might offend other prisoners and had deep-seated worries about the durability of his marriage.

56. The ACCT case review on 4 October listed Mr Sullivan's concerns, which showed that the risks he posed to himself were concrete and the decision to open an ACCT was justified. If the SO had taken into account the appropriate risk factors that Mr Sullivan had outlined, he might have recognised that Mr Sullivan's risk was in fact rising and should have been flagged as raised. The SO expressed the view to the investigator that even if he had been aware of the recent risk information in Mr Sullivan's computerised records, he was satisfied that he would not have made a different decision regarding Mr Sullivan's level of risk. We do not agree. Mr Sullivan's wife told the safer custody administrator that although her husband would try to convince staff he was not at risk, he would try to harm himself. In closing the ACCT on 10 October without considering Mr Sullivan's wife's warning, the SO and nurse were overly persuaded by Mr Sullivan's assertions that he was not distressed and did not intend to harm himself.

Management of suicide and self-harm procedures

57. Mr Sullivan saw a nurse for an initial reception health screen on 12 April but was not referred for a mental health assessment despite disclosing that he experienced psychosis in 2014 and had taken an overdose in 2015. Although he described himself to the nurse as stable, this was a missed opportunity to gather potentially significant information about triggers which might put him at risk of self-harm.

58. An ACCT was opened on 5 September after Mr Sullivan disclosed that his relationship with his wife had broken down and he expressed specific thoughts about hanging himself. The following day, Mr Sullivan assured staff that his situation was all a misunderstanding. Staff closed the ACCT without further exploration. Mr Sullivan's wife played a pivotal role in his life. The lesson that relationship breakdown perceived or actual, could be a significant trigger to future self-harm or suicide was lost. The decision to close the ACCT without any in-depth exploration was premature.

59. After Mr Sullivan was found guilty of his offence, Hull received information that Mr Sullivan was at heightened risk from two sources; his wife and court staff. A court appearance with a negative or unexpected outcome can render a prisoner vulnerable to self-harm. If Hull had collated effectively the information it already had, they might have considered that they needed to put suicide and self-harm procedures into action. Reception staff were aware of Mr Sullivan's wife's concerns but did not update Mr Sullivan's computerised record to reflect that court staff had started a suicide and self-harm warning form. The nurse on duty did not check Mr Sullivan's wellbeing on his return. Neither reception staff nor residential unit staff opened an ACCT on 29 September and did not record in detail their reasons for not doing so. Hull was unable to find the suicide and self-harm warning form mentioned in the two escort records until after Mr Sullivan's death.

60. An ACCT was correctly opened by an officer on 3 October, despite Mr Sullivan's protestations. However, following the first case review, the caremap did not include support from Lifeline, where Mr Sullivan had already built up links while on the recovery wing and it required him to take action himself to reduce his anxiety, which was insufficient to address his risk.

61. Mr Sullivan requested help from the mental health team on two occasions. After the first request he received a booklet on stress management from the mental health team but was not seen in person by a mental healthcare practitioner. At his ACCT case review on 4 October, Mr Sullivan asked to speak to someone from the mental health team as he was anxious following his sentence. A referral was made but the first time he met a mental health nurse was in the context of the ACCT review on 10 October. It was not the forum for Mr Sullivan to speak in private with a nurse. The nurse appears to have used the case review on 10 October as a means of determining whether Mr Sullivan needed a mental health assessment and in his clinical judgement, he did not. While healthcare staff participation in the ACCT process is essential, the ACCT case review was not a substitute for a separate consideration of his circumstances. An opportunity to initiate a mental health assessment was missed which would have provided more information on Mr Sullivan's psychosis and attempted overdose.

62. The SO told the investigator that all he had to go on was Mr Sullivan's outward presentation when they spoke at the case review on 10 October, which he viewed as positive and forward thinking. He was confident that he would have still closed the ACCT that day even if he had been aware of Mr Sullivan's wife's concerns. In 2014 and 2015, we produced Learning Lessons bulletins on risk assessment, gathered from Prison and Probation Ombudsman investigations into self-inflicted death. These bulletins pointed out that, too often, prisons discount known risk factors and place too much emphasis on a prisoner's presentation, with staff too ready to accept assurances that a prisoner has no thoughts of suicide. A prisoner's demeanour can reveal something of their level of risk, but it is only one piece of evidence and a reflection of their state of mind at the moment they are seen. While staff judgement is fundamental to the ACCT process, it must be informed by all available risk information, local and national policies and not merely their presentation. Even if staff accepted Mr Sullivan's assurances that he was not at risk, there were still risks present including his relationship with

his wife, his trial, and his outstanding mental health concerns and as a result, the ACCT was closed with some issues unresolved.

63. Our annual report 2015-16 examined the role of case managers and caremaps in addressing prisoners' risk factors. We observed that too often we find that caremaps are inadequate, failing to identify or address risk factors. A prisoner's caremap should be fundamental to managing their risk of suicide. We have repeatedly found that staff at ACCT case reviews do not complete caremaps properly, make referrals to services with no assessment of whether this has been effective and do not revisit them to check that actions have been completed. We make the following recommendation:

The Governor should ensure staff identify, consider and record all known risk factors of a prisoner when determining the risk of suicide and self-harm.

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

- **A multi-disciplinary case review is held within 24 hours of an ACCT plan being opened.**
- **ACCT case managers use all available information to assess risk and caremap actions.**
- **ACCT documents should only be closed once outstanding issues have been resolved.**
- **The Governor should remind staff of the importance of sharing information and updating computerised records such as NOMIS whenever an event occurs, significant information is received, which suggests an increase a prisoner's risk.**
- **The Governor and Head of HealthCare should ensure that prisoners being at risk of suicide and self-harm and/or with a history of mental health issues are referred urgently for a mental health assessment.**

64. Mr Sullivan's custodial status changed twice within five days when on 29 September, he was convicted of conspiracy to rob and on 3 October he received a long prison sentence of 13 years. Nurses asked Mr Sullivan when leaving for court if he was okay. Crucially, however, he was not spoken to by healthcare staff on his return and reception staff decided not to open an ACCT document despite the suicide and self-harm form initiated by court staff. The SO cited Mr Sullivan's expected contact with healthcare staff in reception as a factor in not relaying Mrs Sullivan's concerns about her husband's risk. A reception officer initiated ACCT procedures on 3 October, which was good practice, but the input of healthcare at that time would have provided an added protective layer of staff concern.

The Governor and the Head of Healthcare should remind staff, in accordance with PSO 3050, Healthcare staff should review a prisoners' wellbeing following a change in their custodial status.

The Governor should ensure that all risk documentation relating to a prisoner is stored securely and should be readily available as necessary.

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Independent Investigations

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