Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Brown a prisoner at HMP Nottingham on 17 September 2017

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*

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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.

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

Mr Andrew Brown died in hospital on 17 September 2017 after being found hanging in his cell at HMP Nottingham five days earlier. He was 42 years old. We offer our condolences to Mr Brown's family and friends.

Mr Brown had a history of chronic obstructive pulmonary disorder, personality disorder, illicit drug use, self-harm and attempted suicide. The investigation found Mr Brown did not receive appropriate mental healthcare while at Nottingham and that suicide and self-harm prevention procedures were not appropriately carried out. There was also an unacceptable delay in responding to Mr Brown's cell bell.

Following its inspection of Nottingham in January 2018, HM Inspectorate of Prisons (HMIP) concluded that the prison was 'fundamentally unsafe' and invoked the Urgent Notification process to alert Ministers to their concerns. We welcome HMIP's decision to do this. Several of the significant failings identified by HMIP featured in this investigation. HMIP also noted that there had been repeated failures by Nottingham to implement our recommendations following previous deaths in custody.

Urgent action needs to be taken to address these issues.

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

Sue McAllister CB
Prisons and Probation Ombudsman **March 2019**

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Summary

Events

1. Mr Andrew Brown had a history of chronic obstructive pulmonary disorder, personality disorder, illicit drug use, self-harm and attempted suicide. Mr Brown had served numerous custodial sentences at HMP Nottingham, and had been released from a previous sentence at Nottingham on 14 August 2017. On 18 August, Mr Brown was remanded into custody at Nottingham once again, charged with assault and criminal damage.

2. On Mr Brown's arrival at Nottingham, staff immediately monitored him under Prison Service suicide and self-harm prevention procedures (known as ACCT) as he had said he had thoughts of suicide when in court.

3. On 12 September, at 3.45pm, an officer found Mr Brown hanging in his cell. The officer requested an ambulance and began cardiopulmonary resuscitation (CPR). Both officers and medical staff attended, and CPR continued until paramedics arrived. The paramedics took over emergency treatment and took Mr Brown to the intensive care unit at a hospital where he was placed on life support. On 17 September, hospital doctors withdrew life support and at 9.00pm Mr Brown was pronounced dead.

Findings

Management of risk of suicide and self harm

4. We found that ACCT procedures at Nottingham were not conducted in line with mandatory national instructions. Some reviews were not completed when required, not all case reviews were multidisciplinary, and there were some inappropriate assessments of Mr Brown's risk of self-harm.

5. After the ACCT was closed on 6 September, Mr Brown made no further attempts at self-harm until 12 September, and gave staff no indication that he had further thoughts of suicide.

Clinical care

6. The clinical review concluded that the physical care provided to Mr Brown was equivalent to that which he could have expected to receive in the community.

7. However, the clinical review concluded that the mental health care provided to Mr Brown was not equivalent to that which he could have expected to receive in the community. He was referred to the mental health team by the nurse in reception when he arrived at Nottingham on 18 August, but had not received a mental health assessment by 12 September. As a result, Mr Brown had no mental health interventions.

Answering a cell bell

8. We found that after Mr Brown pressed his cell bell at 3.01pm on 12 September, it was not answered for 44 minutes. Her Majesty's Inspectorate of Prisons has an

expectation that cell bells should be answered within five minutes and this is the standard against which we expect prisons to deliver.

Actions following a death in custody

9. We found that following Mr Brown's death, procedures at Nottingham were not conducted in line with mandatory national instructions. There was no debrief of the staff involved in the emergency response and staff were not instructed to complete incident report forms.

Recommendations

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

  - conducting ACCT reviews as specified in the national instructions;
  - assessing the level of risk and recording the reasons for decisions;
  - setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;
  - conducting ACCT post-closure interviews as specified in the national instructions; and
  - considering information from all sources and recording all the known risk factors of a prisoner when determining their risk of suicide or self-harm

- The Head of Healthcare, the healthcare commissioners and the Governor should review the mental health care provision at HMP Nottingham. The review should consider the capacity to deliver a seven-day service of mental heath assessments and ongoing interventions effectively, and the availability of staff to support the ACCT process.

- The Governor should ensure that all cell bells are answered within five minutes.

- The Governor should ensure that all relevant mandatory actions in PSI 64/2011 are completed after a prisoner's death.

The Investigation Process

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

11. The investigator visited Nottingham on 21 September. He obtained copies of relevant extracts from Mr Brown's prison and medical records.

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

13. The investigator interviewed 11 members of staff at Nottingham in October. Four interviews were conducted jointly with the clinical reviewer.

14. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. She gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Brown's brother, to explain the investigation and to ask whether there were any matters he wanted the investigation to consider. Mr Brown's brother did not raise any concerns.

Background Information

HMP Nottingham

16. HMP Nottingham is a local prison holding a maximum of 1060 men and young adult prisoners on remand, convicted or sentenced. The prison serves the courts of Nottinghamshire and Derbyshire. Nottinghamshire Healthcare NHS Foundation Trust provides health services, including mental health services. The prison has 24-hour primary healthcare cover. Mental health care is available Monday to Friday, 8.00am to 5.00pm.

17. D Wing at HMP Nottingham functions as the Induction wing. The wing can hold maximum capacity of 155 prisoners. All cells are suitable for double occupancy, although prisoners assessed as at raised risk occupy a cell on their own. The 4's landing acts as the overspill for the vulnerable prisoner (VP) unit, G Wing. On occasions the 3's landing is also used when there is a high number of vulnerable prisoners. Prisoners granted VP status remain on D Wing until a space becomes available on G Wing. On average there are 15 to 20 prisoners monitored under self-harm prevention measures on D Wing at any one time.

18. The regime on the wing allows half of the prisoners association in the morning and the remainder in the afternoon. At other times, unless unlocked for appointments or visits, prisoners remain in their cells. There are two meals served: lunch and an evening meal. Prisoners are issued with breakfast packs with their evening meal. The majority of prisoners, apart from prison orderlies, are locked in their cells by 6.00pm, and all prisoners are in their cells by 7.00pm until the following morning. As a consequence of the regime prisoners remain in their cells for more than 50% of their day.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Nottingham during the week of 8 January 2018, which found the prison to be fundamentally unsafe. On 18 January 2018, HMIP invoked the Urgent Notification (UN) process which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. The Secretary of State responded on 12 February.

20. Key findings from the inspection included:

    - Over two thirds of prisoners told inspectors they had felt unsafe at some point during their stay at the prison.
    - Over a third of prisoners said they felt unsafe at the time of the inspection.
    - Levels of self-harm remained very high and had increased since the last inspection in February 2016. In a survey, 30% of prisoners said that they had been subject to case management interventions (ACCT) at some point during their stay, but too many prisoners felt the support and engagement offered was either insufficient or inconsistent.

- Levels of violence overall were higher than in comparable prisons and had not reduced since the last inspection in February 2016.
- Only 14% of prisoners said that their cell bell was normally answered within five minutes and there were examples of long delays.
- There were repeated failures to achieve or embed improvements following previous recommendations made by the Prisons and Probation Ombudsman (PPO).

Independent Monitoring Board

21. 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 annual report, published in July 2017, the IMB were very concerned about the levels of self-harm and violence and believed that staff shortages and the availability of illicit drugs were a factor in this. The IMB noted that the restricted regime meant all landings were unlocked for domestic activity in either the morning or afternoon, but those prisoners not allocated a regime activity were locked in their cell for the rest of the day.

Previous deaths at HMP Nottingham

22. Mr Brown's was the seventh death to occur at Nottingham since 1 January 2016. Five of the previous deaths were self-inflicted and one was due to natural causes. Five prisoners have taken their own lives since Mr Brown's death. Between 13 September and 12 October 2017, five prisoners died at Nottingham including Mr Brown.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

24. Mr Andrew Brown had a custodial history dating back to 2001. He had served numerous sentences at HMP Nottingham. He had a history of chronic obstructive pulmonary disorder (COPD), personality disorder, illicit drug use, self-harm and attempted suicide. Mr Brown was released from his last sentence at Nottingham on 14 August 2017.

25. On 18 August 2017, Mr Brown appeared at North Derbyshire Magistrates Court and was remanded into custody charged with assault and criminal damage. A Prison Custody Officer (PCO) completed a Person Escort Report (PER) and a Suicide and Self-Harm Warning (SSHW) form. These documents are intended to alert staff in all criminal justice agencies who come into contact with a prisoner, about his or her risk of suicide and self-harm. The PCO noted on the forms that Mr Brown had said he would kill himself and that he had a history of self-harm. The escort record and the SSHW form accompanied Mr Brown to Nottingham.

26. A supervising officer (SO) saw Mr Brown when he arrived in reception at 1.50pm. He signed the PER and SSHW forms and immediately opened an ACCT. He assessed Mr Brown as being high risk and his level of observations was set at hourly throughout the day and night until the first case review.

27. A nurse saw Mr Brown in reception. The nurse recorded that Mr Brown was on an ACCT and had a history of self-harm and current suicidal thoughts. The nurse recorded that Mr Brown suffered from COPD and was prescribed clenil modulite and salbutamol (medication for the treatment of asthma and COPD). The nurse referred Mr Brown to the mental health team. The SSHW form was not signed by a member of healthcare.

28. That evening, a prison doctor prescribed at 28-day supply of clenil modulate and salbutamol.

29. On 20 August, at 11.10am, a supervising officer (SO) assessed Mr Brown as part of ACCT procedures. (It is mandatory for the ACCT assessment to be held within 24 hours of an ACCT being opened; this assessment should have taken place on 19 August.) Mr Brown said he had suffered thoughts of self-harm and was low in mood. He said he had head-butted the walls since he arrived at Nottingham but did not see this as self-harm. Mr Brown said he had no current suicidal thoughts and wanted help from the mental health team.

30. At 11.20, the SO held the first ACCT case review with Mr Brown. No one else was present. No one from healthcare attended or had any input into the review. (It is mandatory for first case reviews to be held within 24 hours of an ACCT being opened; this first case review should have taken place on 19 August.) Mr Brown said that he had no current thoughts of self-harm and wanted the ACCT to remain open until he had seen the mental health team. He assessed Mr Brown as being at low risk of suicide and self-harm, and reduced the level of observations to two conversations during the day and two observations during the night. The SO completed the ACCT caremap which contained two actions: for Mr Brown to have a mental health assessment, and for Mr Brown to obtain a job. The next case review was set for 25 August.

31. The SO told the investigator that he was the only trained ACCT assessor on duty covering the weekend of 19 and 20 August. He said that no one from healthcare was available and mental health nurses only work Monday to Friday.

32. On 22 August, a resettlement case worker saw Mr Brown. Mr Brown said he had no thoughts of self-harm or suicide. He said he was aware of the support services on offer at Nottingham and knew how to access these. Mr Brown said he did not use any new psychoactive substances (NPS) or alcohol as he was a religious man and only used religious incense which was not harmful. She recorded that she informed Mr Brown that once he had been sentenced she would work with him to secure accommodation on his release and how to access state benefits. She also referred Mr Brown to the mental health team.

33. On Saturday 26 August, a SO held an ACCT case review with Mr Brown. No-one else was present and no one from healthcare had any input into the review. (This review should have taken place on 25 August.) Mr Brown said he was in good spirits and had no thoughts of self-harm at that time although he was frustrated about being back in prison. The SO assessed Mr Brown as being at a low risk of suicide and self-harm, and amended the level of observations to one conversation in the morning and afternoon and hourly observations during the night.

34. On 31 August, a SO chaired an ACCT case review with two nurses, both members of the mental health team, and Mr Brown present. Mr Brown said he had written a suicide note a few days earlier but had not acted upon it. He said he suffered with disturbed sleep and wanted help with this. It was noted that Mr Brown was due to have appointments with the dentist and the mental health team. All present at the review assessed Mr Brown as being at a low risk of suicide and self-harm, and the level of observations remained unchanged. The next review was scheduled for 6 September.

35. On 6 September, a SO chaired an ACCT case review with a nurse who was a member of the mental health team, and Mr Brown present. Mr Brown said he felt much better in himself and going to chapel had helped him a lot. The SO and nurse agreed that Mr Brown's risk of suicide and self-harm was low and agreed to close the ACCT. The caremap was not updated and the actions had not been completed. A post-closure review was scheduled for 13 September. No further interactions with Mr Brown are recorded in wing observation books before his death.

36. Mr Brown's medical records show that a mental health assessment was scheduled for 19 September. Two nurses told the investigator that prisoners referred to the mental health team should be seen for an initial assessment no later than five working days, or within 24 hours if the referral is deemed urgent.

37. A custodial manager (CM) on D wing, told the investigator that the regime on the wing meant that half of the prisoners were allowed association in the morning and the remainder in the afternoon. At all other times, unless unlocked for appointments or visits, prisoners remained in their cells. The CM said that on average there were 15 to 20 prisoners subject to ACCT monitoring on D Wing at any one time.

38. The Head of Security, told the investigator she knew Mr Brown from his previous sentences at Nottingham. She said that during his last sentence, Mr Brown had assaulted three members of staff while apparently under the influence of NPS. These matters were referred to the police at the time and the outcome of the police investigation was still awaited. She said there was no evidence or intelligence that Mr Brown had used illicit drugs, was in debt or was bullied since his arrival at Nottingham on 18 August.

39. On the 8 and 11 September, Mr Brown appeared at Derby Crown Court via video link. On each occasion, Mr Brown was further remanded in custody. He was scheduled to appear in person at Derby Crown Court on 29 September.

40. Mr Brown's prison phone records show that he called a friend on 8, 10 and 11 September. The investigator has listened to each of these calls and at no time did Mr Brown say, or give any indication, that he had thoughts of harming himself.

Events of 12 September

41. On 12 September, at 9.27am, Mr Brown's prison phone records show that he called his solicitor. This call lasted for six minutes and 53 seconds. Calls made to legal representatives are not recorded. At 10am, Mr Brown also called his friend and this call lasted for two minutes 34 seconds. The investigator has listened to this call and Mr Brown did not say, or give any indication, that he had thoughts of harming himself.

42. CCTV footage of the wing shows that at 2.55pm Mr Brown's cell bell light came on. (Prisoners have a button in their cell which they can press to summon urgent assistance from staff. When the cell bell is activated this illuminates a light outside the cell which remains on until a member of staff comes to the cell and deactivates it.) A physical education instructor, was walking down the wing and answered Mr Brown's cell bell.

43. The physical education instructor told the investigator that she did not know it was Mr Brown's cell until she turned the light off and opened the observation panel in the cell door. She said she knew Mr Brown from his previous sentences at Nottingham and he had spoken to her on numerous occasions about his faith. She told the investigator she could not remember what Mr Brown said to her that afternoon. She said she spoke with him for less than two minutes and she had no concerns about him.

44. The CCTV footage shows Mr Brown's cell bell light coming on again at 3.01pm. An officer told the investigator that at that time he was in the wing office and the only officer on the wing. He said the librarian had bought two books for Mr Brown, so he took them to him. At 3.44pm, CCTV footage shows that the officer arrived at Mr Brown's cell carrying two books.

45. The officer told the investigator that when he got to Mr Brown's cell, he opened the observation panel and saw Mr Brown hanging from the window bars in his cell by a ligature made from bedding. The officer shouted for staff, immediately entered the cell, cut the ligature and lowered Mr Brown to the floor. Another officer arrived at the cell. The officer immediately radioed a code blue

emergency, which indicates a prisoner is unable, or having difficulty breathing, and both officers began cardiopulmonary resuscitation (CPR). The control room log shows the code blue was called over the radio at 3.45pm and an ambulance was called immediately.

46. Two nurses immediately responded to the code blue call. The nurses continued with the resuscitation and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so the nurses continued with CPR.

47. Paramedics arrived at 3.58pm and took over Mr Brown's care. They continued with CPR and, after a period of treatment, paramedics transferred Mr Brown to the intensive care unit at the hospital, where he was placed on life support.

48. Staff noticed that Mr Brown had written several notes. In one of these, Mr Brown indicated that he had planned to end his life as he wrote, "Do not resuscitate, this has taken courage and has been thought through."

49. Healthcare staff at Nottingham maintained daily contact with the hospital for updates on Mr Brown's condition. Hospital doctors confirmed that the prognosis for Mr Brown was very poor. On 17 September, the hospital informed healthcare staff that, following the withdrawal of life support, Mr Brown died at 9.00pm that evening.

Contact with Mr Brown's family

50. Mr Brown had not had any contact with his family for a number of years. A family liaison officer (FLO), managed to trace Mr Brown's brother and spoke to him on 13 September at 12.15pm, letting him know what had happened. The FLO also spoke to Mr Brown's sisters. Mr Brown's brother and sisters visited him in hospital and were told that his prognosis was very poor. Mr Brown's family asked the hospital to inform them when Mr Brown died.

51. After Mr Brown died on 17 September, the hospital informed his family as they had requested. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

52. Two officers and a nurse each told the investigator that they had not been involved in a debrief following the incident. The investigator has not been provided with a copy of any minutes of a debrief. Nor were staff members asked to complete incident report forms. (It is a mandatory requirement to hold a debrief for staff involved in an emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, for managers to offer support, and for staff to complete incident report forms as soon as practicable.) Both officers said the staff care team offered support.

53. The prison posted notices informing staff and prisoners of Mr Brown'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 Brown's death.

Post-mortem report

54. A post-mortem examination, conducted by a doctor confirmed that the cause of Mr Brown’s death was hypoxic brain injury caused by hanging. The doctor noted that the toxicology results confirmed that Mr Brown was not under the influence of alcohol or any illicit drugs at the time of his death.

Findings

Management of risk of suicide and self harm

55. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

56. Staff correctly opened an ACCT on 18 August, immediately on Mr Brown's arrival at Nottingham. However, national instructions explicitly state it is mandatory that the ACCT assessment and first case review should be completed within 24 hours of an ACCT being opened. This did not happen on time. Both the ACCT assessment and first case review were held on 20 August

57. After a SO completed the assessment, he then conducted the first case review with no one else present and without any input from healthcare staff. The SO told the investigator he was the only trained ACCT assessor/case manager member of staff on duty that weekend. We consider that this is unacceptable.

58. The next case review was scheduled for 25 August but was not held until 26 August. This review was conducted by a SO and, again, he did this review on his own, without anyone else present and without any input from healthcare staff. The SO assessed that Mr Brown was at low risk of self-harm.

59. We consider that staff made an inappropriate assessment of Mr Brown's risk on 31 August. At this review, Mr Brown said he had written a suicide note only a few days earlier but had not acted on it. He said he suffered with disturbed sleep and wanted help with this. In completing the record of the case review, a SO did not indicate Mr Brown's level of risk or whether the caremap had been reviewed.

60. Given that Mr Brown had said he had written a suicide letter and the lack of progress in delivering the caremap actions, we consider it more likely that Mr Brown was at raised risk of suicide. Consideration should have been given to increasing his level of observations. In addition, the caremap should have been updated with an additional action to address Mr Brown's poor sleep through an appointment with a doctor.

61. We consider that the decision to close the ACCT on 6 September was inappropriate and consider that Mr Brown should have received appropriate ongoing support from staff at the very least until after the mental health assessment had taken place. The actions on the caremap were not completed as Mr Brown had yet to have a mental health assessment and did not yet have a job.

62. It is impossible to know, if the ACCT had remained open and Mr Brown had received ongoing support along with a mental health assessment, whether staff at Nottingham could have done anything to prevent his actions. We make the following recommendation:

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

- **conducting ACCT reviews as specified in the national instructions;**
- **assessing the level of risk and recording the reasons for decisions;**
- **setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;**
- **conducting ACCT post-closure interviews as specified in the national instructions; and**
- **considering information from all sources and recording all the known risk factors of a prisoner when determining their risk of suicide or self-harm.**

Clinical Care

63. The clinical reviewer considered that the physical care that Mr Brown received from healthcare staff at HMP Nottingham was equivalent to the care he would have received in the community.

64. However, the clinical reviewer had serious concerns about the standard of mental healthcare and considered that this was not equivalent to the care Mr Brown could have expected to receive in the community.

65. The clinical reviewer was concerned that the only contact Mr Brown had with mental health services was during the ACCT process. He commented that Mr Brown was very well known to staff at Nottingham from previous sentences and his particular character was well documented in his medical records. This familiarity with Mr Brown may have impacted on the level of urgency assigned to his care.

66. The clinical reviewer was also concerned that, on 31 August, despite Mr Brown's ongoing thoughts of taking his own life, he had not been seen for an initial mental heath assessment. A nurse said at the ACCT review that Mr Brown's presentation was very animated, with good eye contact. Despite talking about suicide, the impression he gave her was that his faith was a protective factor that would prevent him from taking his own life.

67. The clinical reviewer commented that a nurse's rationale for closing the ACCT on 6 September was based on Mr Brown being very well known to mental health services, and that his presentation at the ACCT review was not out of character and raised no concerns. However, no mental health assessment had yet taken place and Mr Brown had said on 20 August, that he wanted the ACCT to remain open until he saw the mental health team.

68. Two nurses said prisoners referred to the mental health service should be seen within five working days, or within 24 hours if it is deemed urgent. A nurse said that at the time of Mr Brown's death it took up to three weeks for a prisoner to be

seen after a referral had been received. Both nurses also said the requirement to support ACCT processes had a serious impact on mental health service delivery at Nottingham.

69. Mr Brown's medical records show that he had a mental health assessment scheduled for 19 September. This is four weeks from the date of the initial referral made in reception by a nurse and from the subsequent referral by a resettlement case worker on 22 August.

70. We agree with the clinical reviewer conclusion that the mental healthcare that Mr Brown received was not equivalent to that which he could have receive in the community. It is impossible to know, if Mr Brown had received appropriate mental healthcare, whether staff at Nottingham might have prevented his actions. We make the following recommendation:

The Head of Healthcare, the healthcare commissioners and the Governor should review the mental health care provision at HMP Nottingham. The review should consider the capacity to deliver a seven-day service of mental health assessments and ongoing interventions effectively, and the availability of staff to support the ACCT process.

Answering a cell bell

71. Mr Brown pressed his cell bell at 3.01pm, 44 minutes before he was found hanging. HMIP has an expectation that cell bells should be answered within five minutes and this is the standard against which we expect prisons to deliver. The bell was not answered until 3.45pm, when an officer happened to go to Mr Brown's cell to deliver two books from the library and found Mr Brown hanging. This delay in answering a cell bell is unacceptable. It is impossible to say whether a more prompt response to Mr Brown's cell bell would have saved his life or made a difference to the outcome, but it must remain a possibility. We make the following recommendation:

The Governor should ensure that all cell bells are answered within five minutes.

Actions following a death in custody

72. PSI 64/2011 sets out the actions that prisons should undertake after a prisoner's death. Chapter 12 of the PSI contains a mandatory action that a 'Hot Debrief' must be held immediately after a death in custody. A senior member of staff must act as a debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. Staff told the investigator they did not attend a debrief and there is no record of a debrief taking place.

73. In addition, staff directly involved, particularly those who were first on scene, must complete Incident Report Forms as soon as practicable. No members of staff were asked to complete the forms after the initial emergency incident or after Mr Brown died. We make the following recommendation:

The Governor should ensure that all relevant mandatory actions in PSI 64/2011 are completed after a prisoner's death.

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