Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Benjamin Ireson a prisoner at HMP Nottingham on 13 December 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.

Mr Benjamin Ireson was found hanged in his cell at HMP Nottingham on 13 December 2018. He was 31 years old. I offer my condolences to Mr Ireson's family and friends.

Mr Ireson, a remand prisoner, arrived at Nottingham on 16 October. One week later, staff started Prison Service suicide and self-harm prevention procedures (known as ACCT) after Mr Ireson said he felt like slashing his wrists because he did not feel safe on the wing. Staff stopped ACCT monitoring two days later. He was not being monitored when he died.

The investigation found that staff stopped ACCT monitoring prematurely and an opportunity was missed to put measures in place to support Mr Ireson. It also found record keeping was poor with scant entries in Mr Ireson's prison record, which meant that wing staff were not aware of information that might have affected his risk of suicide and self-harm.

I am also concerned that there was a delay in Mr Ireson being seen by the mental health team, despite being referred on the day he arrived and again during ACCT monitoring.

We have expressed serious concerns about deficiencies in the management of suicide and self-harm procedures at Nottingham in previous investigations. Following an inspection of the prison in January 2018, HM Chief Inspector of Prisons described the prison as "fundamentally unsafe". He invoked the Urgent Notification protocol and wrote to the Secretary of State setting out his significant concerns about the safety of prisoners at Nottingham.

The Secretary of State responded in February 2018 with an action plan to deliver improvements and said, among other things, that a package of measures to address the prison's safety needs would be developed by the end of March 2018. This would include ensuring that recommendations from the PPO were implemented.

I am, therefore, very concerned to find the same failings again in Mr Ireson's case, as well as in two previous self-inflicted deaths at the prison in October and November 2018. It seems that the lessons from previous investigations are simply not being learned. I am copying this report to Secretary of State to make him aware of my concerns.

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 **October 2019**

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Summary

Events

1. Mr Benjamin Ireson was remanded in prison custody on 16 October 2018, after being charged with violent offences against his partner. He was sent to HMP Nottingham.

2. On 22 October, Mr Ireson told staff he felt under threat on the wing and felt like slashing his wrists before someone else did. Staff started suicide and self-harm monitoring procedures (known as ACCT) but stopped them two days later when Mr Ireson said he felt better.

3. Mr Ireson told staff that he did not get on with his cellmate but did not want to be on his own as he got lonely. On 28 October, Mr Ireson was moved to a different cell on the same wing, with no cellmate.

4. On 13 November, Mr Ireson attended court by videolink. He pleaded not guilty to the charges against him and he was further remanded in custody with a trial date in April 2019.

5. On 18 November, Mr Ireson attended an ACCT post-closure review. He said that his issues had been resolved and that he preferred to deal with his problems alone. Mr Ireson said he was not engaging in any activity or employment and that he wanted to keep himself to himself.

6. On 9 December, Mr Ireson was moved to another cell on the wing, again with no cellmate. It is unclear why he was moved.

7. On 13 December at 5.45am, an operational support grade (OSG) was carrying out checks on the wing when he saw that Mr Ireson had covered his observation panel with toilet paper. The OSG could not get a response from him. The OSG saw through a gap in the paper that Mr Ireson was hanging from his wardrobe. The OSG shouted to a colleague who joined him outside the cell, and then he radioed a medical emergency code. He went to get the cell key but by the time he returned, other staff had arrived and entered the cell. They cut down Mr Ireson and started cardiopulmonary resuscitation (CPR).

8. Healthcare staff arrived shortly afterwards and told prison staff to stop CPR as there were signs Mr Ireson had already died. Paramedics arrived at 6.00am and confirmed that Mr Ireson was dead.

Findings

9. We consider that staff stopped ACCT procedures prematurely and that an opportunity was missed to put measures in place to support Mr Ireson. The ACCT post-closure interview was inadequate and was carried out almost three weeks late.

10. No one checked on Mr Ireson after he attended court by videolink and was remanded in prison for a further five months. No note was made in his prison record, so wing staff were unaware of this.

11. There was poor record keeping and information sharing generally. Entries on Mr Ireson's prison record were sparse, and at times, significant information was not recorded at all.

12. Staff made a mental health referral for Mr Ireson on 16 October and again on 22 October, but he was not seen until 12 November. This was outside the mental health team's aim of seeing prisoners within five working days.

13. The OSG who discovered Mr Ireson hanging did not have his cell key on him as he should have done and had to go to an office to collect it from a bag. This caused a short delay in staff entering the cell and starting CPR, although we are satisfied that this did not affect the outcome for Mr Ireson.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that they:
    - assess the level of a prisoner's risk based on all available information and known risk factors rather than relying on the prisoner's presentation;
    - stop ACCT procedures only once they are satisfied that the prisoner's risk has reduced, and record the reasons for the decision;
    - hold post-closure interviews within seven days of closing an ACCT; and
    - ensure that the post-closure interview covers the progress the prisoner has made since the ACCT was closed and this is fully recorded.
- The Governor should ensure that arrangements are in place to identify prisoners who may be at increased risk of suicide and self-harm, or require a healthcare assessment, following a court appearance by videolink.
- The Governor should ensure that staff record all relevant information in prisoners' records (NOMIS), regardless of their custodial status, in particular:
    - information that may have an impact on prisoners' wellbeing such as ACCT reviews, court appearances, cell moves, and engagement in activities; and
    - that appropriate follow-up action is taken, as necessary to offer support to prisoners where such issues have been identified and recorded.
- The Head of Healthcare should review the management of the mental health assessment waiting list to achieve the five-day waiting time standard.
- The Governor should ensure that all staff are aware of Nottingham's Local Security Strategy and PSI 55/2011 on carrying and using cell keys so that they are able to enter a cell in an emergency, without delay.

The Investigation Process

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

15. The investigator obtained copies of relevant extracts from Mr Ireson's prison and medical records.

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

17. The investigator interviewed six members of staff and five prisoners at HMP Nottingham. The interviews took place between December 2018 and May 2019.

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

19. One of the PPO's family liaison officers wrote to Mr Ireson's mother to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Ireson's mother appointed a solicitor who responded on the family's behalf. The family wanted to know:

    - whether Mr Ireson was being bullied;
    - why he moved cells;
    - whether there was any input from the mental health team or if he was on any mental health medication; and
    - why there had been limited contact from the prison's family liaison officer.

20. We have addressed these questions in this report.

21. We shared our initial report with the solicitor representing Mr Ireson's family. The family raised issues which did not affect the factual accuracy of this report, so these issues have been addressed in separate correspondence with the family's solicitor.

22. We shared our initial report with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Nottingham

23. HMP Nottingham is a local prison holding a maximum of 1,060 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 seven days a week, 8.00am to 5.00pm.

HM Inspectorate of Prisons

24. 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". 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;
- eight prisoners had taken their own lives since the last inspection; and
- there had been repeated failures to achieve or embed improvements following previous recommendations made by the Prisons and Probation Ombudsman.

25. 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.

26. The Secretary of State responded on 12 February 2018 with an action plan to deliver improvements. He said, among other things, that an urgent safety audit had been carried at Nottingham, focusing on violence reduction, suicide prevention and self-harm reduction, and that a safety taskforce of specialist safety staff would be deployed to work intensively with the prison and the regional safer custody team to develop a package of measures by the end of March 2018 to address the prison's safety needs. This would include ensuring that recommendations from the PPO were implemented.

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 annual report for reporting year 2017-18, 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 Nottingham

28. Mr Ireson was the 13th prisoner to die at Nottingham since December 2016. Nine of the previous deaths were self-inflicted, one was a homicide, one was drug-related and one was from natural causes. Of these, four self-inflicted deaths (including Mr Ireson's) and one homicide have taken place since February 2018.

29. Most of the PPO's previous self-inflicted investigations have identified deficiencies in identifying risk factors and in managing suicide and self-harm procedures (ACCT). We have also made recommendations about answering cell bells promptly, recording and sharing information, meaningful contact between prisoners and staff, and timescales for mental health assessments. We are very concerned that we have continued to find the same deficiencies in our investigations into self-inflicted deaths since February 2018, notwithstanding the Secretary of State's response to HMIP's Urgent Notification.

Assessment, Care in Custody and Teamwork

30. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

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

32. 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.

Key Events

33. Mr Benjamin Ireson was remanded in prison custody on 16 October 2018 and sent to HMP Nottingham. He faced charges for violent offences against his partner and there was a non-contact order in place. Mr Ireson had only been in prison once before, for a week at HMP Bedford in 2012.

34. When he arrived at Nottingham, Mr Ireson told a nurse that he had no physical health problems but had a history of insomnia and anxiety, although he was not taking any medication. Mr Ireson also said that he used cannabis in the community. The nurse referred Mr Ireson to the mental health team and the substance misuse team.

35. As part of the reception process, Mr Ireson was interviewed by an officer from the safer custody team. He told her that he did not like to spend time alone as he felt isolated. He said he had recently broken up with his partner and did not feel that the relationship could be salvaged. He said that he had no recent history of self-harm and no current thoughts of self-harm, but had attempted suicide in the past after a previous relationship broke down. Staff monitored Mr Ireson in the first night centre and then moved him to a shared cell on B Wing the next day.

36. On the morning of 22 October, a prison offender manager went to Mr Ireson's cell to ask him to sign a public protection document about having no contact with his partner. Mr Ireson spoke to her through the cell door and said that he did not want to sign the document. He said that he was under threat on the wing and needed to move to a different cell. She noted in his record that Mr Ireson passed her an application requesting a cell move and she put this in the applications request box on the wing. She also recorded that she had sent an email to the safer custody team and submitted an intelligence report.

37. During the afternoon of 22 October, the prison offender manager wrote in Mr Ireson's record that he had approached her twice while she was on B Wing and repeated what he told her earlier about being under threat. He said that he had been robbed three times. She wrote that Mr Ireson was upset, stressed and agitated and said other prisoners had taken everything from his cell. He said he could not even make himself a drink because everything had been taken. She wrote that Mr Ireson told her he felt like slashing his wrists and hurting himself before someone else did and he said he was feeling depressed.

38. The prison offender manager reported her concerns to the wing staff and submitted an intelligence report. She also started ACCT monitoring and Mr Ireson was observed at hourly intervals. A Supervising Officer (SO) made a further referral to the mental health team as part of the ACCT immediate action plan.

39. On 23 October, Mr Ireson attended an ACCT assessment interview with a SO. He said he was being bullied on B Wing and that he had asked for a move but felt no one was listening. Mr Ireson told him that he had self-harmed in the past and was worried that his feelings of anxiety and depression would get worse, although he said he did not have any current thoughts of self-harm. He said he was having problems with his cellmate but said he did not want to be on his own as he got lonely.

40. On 24 October, Mr Ireson attended his first ACCT case review which was chaired by a SO and also attended by a nurse from the mental health team. The SO noted that Mr Ireson had no thoughts of suicide or self-harm. She wrote that Mr Ireson said he felt okay and just wanted a cellmate he could get along with. She assessed Mr Ireson's risk as low and recorded that she felt the crisis period had passed so she stopped ACCT monitoring. She scheduled an ACCT post-closure interview to take place by 31 October.

41. On 25 October, Mr Ireson saw a nurse in the substance misuse team. He recorded in Mr Ireson's medical notes that he told him he used cannabis in the community but did not feel the need to engage with substance misuse treatment in custody. He wrote that he advised Mr Ireson what to do if he should feel the need for substance misuse support later.

42. On 28 October, Mr Ireson was moved into another cell on B Wing. He did not have a cellmate.

43. On 31 October, an offender supervisor again asked Mr Ireson to sign the public protection document on having no contact with his partner and an ex-partner. Mr Ireson said that he had no contact with either person and he did not see any reason to sign the document. The offender supervisor told the investigator that it is not uncommon for prisoners to refuse to sign such documents. He said it was his responsibility to explain the document to the prisoner in the interests of public protection, but he would not have been expected to discuss anything else with Mr Ireson, such as how he might have been feeling about the offences or the non-contact orders. He said that, as Mr Ireson was a remand prisoner, he would not have had an allocated offender supervisor but he could have used the offender management unit (OMU) drop-in service to discuss any aspects of his case or court appearances.

44. On 12 November, Mr Ireson saw a nurse for a mental health triage assessment. He recorded in Mr Ireson's medical notes that he told him he did not want to engage with the service as he had asked for help four weeks ago and did not get it. He discharged Mr Ireson from the mental health services but advised him to contact them if he needed any support in the future.

45. On 13 November, Mr Ireson attended court by videolink. He pleaded not guilty to the charges against him and he was further remanded in custody with a trial date in April 2019. An officer completed the videolink result sheet and sent it to the offender management unit, in accordance with the videolink process. However, no other record was made of Mr Ireson's court appearance so the staff on B Wing were unaware that he had attended court or that he had been remanded for a further five months.

46. An offender supervisor told the investigator that OMU staff normally work with prisoners once they have been sentenced and, although he had contact with Mr Ireson about the non-contact orders in place, he was unaware that Mr Ireson had attended court by videolink. A Custodial Manager (CM) on B Wing told the investigator that it was common for prisoners to attend court by videolink and for wing staff not to be made aware. No one checked on Mr Ireson's welfare after his videolink court appearance.

47. On 18 November, Mr Ireson attended an ACCT post-closure review (which should have taken place by 31 October) with a SO. She recorded that Mr Ireson said his issues had been resolved but he said he would not turn to anyone for support as he preferred to deal with his problems alone. She wrote that Mr Ireson was not engaging in any activity or employment and that he said it was normal for him to keep himself to himself. Mr Ireson did not complete the ACCT procedure questionnaire.

48. The SO told the investigator that she did not know that Mr Ireson had appeared in court by videolink and faced a longer period in prison awaiting trial. She could not say why the post-closure interview was carried out late and she could not remember anything about the interview, other than what she had written on the document. She did not recall having any concerns about Mr Ireson.

49. On 9 December, Mr Ireson was moved to another cell on B Wing. He did not have a cellmate. We have been unable to establish the reason for this move. A CM told the investigator that it was unusual for prisoners to move to a different cell if there were no problems and he would have expected to see the reason for the move recorded in Mr Ireson's record. A SO also said that there would usually be a specific reason for moving a prisoner to a different cell but she did not know the reason why Mr Ireson was moved.

Events of 13 December 2018

50. On 13 December at 5.45am, a night operational support grade (OSG) was carrying out checks on B Wing when he noticed that the observation panel on Mr Ireson's cell had been covered with toilet paper. He could not get a response from Mr Ireson. He looked through a small gap in the paper and thought he could see Mr Ireson hanging from the wardrobe. He shouted to one of his colleagues, an officer who came to the cell and agreed with him that they needed to go in.

51. The OSG then used his radio to call an emergency code blue (used to indicate that a prisoner is unconscious or having difficulty breathing) which tells the control room to call an ambulance immediately, and went to get the cell key. By the time he returned, a CM and an officer had arrived at the cell and the CM was opening the door with his key. The CM and the officer cut Mr Ireson down and started cardiopulmonary resuscitation (CPR). A nurse arrived shortly afterwards and noted that rigor mortis was present so she advised the CM to stop CPR. Paramedics arrived at 6.00am and confirmed that Mr Ireson was dead.

Information obtained after Mr Ireson's death

52. A prisoner in the cell next door to Mr Ireson's, told the investigator that Mr Ireson had been complaining that he did not have a television in his cell. He said that he saw staff put a television in the cell after Mr Ireson's death and other prisoners also said that they had heard this is what happened.

53. The investigator spoke to members of staff who said they could not remember if there was a television in Mr Ireson's cell. He was on the standard regime so there was no reason why he would not have had one. No members of staff we spoke to could remember Mr Ireson complaining that he did not have a television

but, equally, no one was able to say with any certainty that he did have one. There is no record kept of which cells have televisions and which cells do not.

54. Although we viewed CCTV of the corridor outside Mr Ireson's cell from the morning of 13 December, there is 20 minutes of unavailable footage from 9.02am to 9.17am, and 9.28am to 9.34am. The prison has said that this was "due to the incident timing out on our system". We have, therefore, been unable to establish if Mr Ireson had a television in his cell and we cannot say whether anyone put a television in the cell during the gaps in the CCTV footage.

55. The prisoner in the cell next door to Mr Ireson's also told the investigator that Mr Ireson had been pressing his cell bell during the night. He said that Mr Ireson sounded upset and told a female officer that he felt like killing himself. He said that the female officer told Mr Ireson to go ahead and do it. Another prisoner in the other neighbouring cell, said that he did not hear Mr Ireson's cell bell or any officer outside his cell during the night and we found no evidence of this from the cell bell records, CCTV or interviews with staff.

56. An unsigned letter was found in Mr Ireson's cell in which he apologised to his partner for his behaviour. The letter did not say that he intended to take his life.

Contact with Mr Ireson's family

57. Mr Ireson's mother was listed as his next of kin. The prison's family liaison officer and a prison manager went to Mr Ireson's mother's address at approximately 11.00am on 13 December but she was not at home. A neighbour told them that she was probably at her daughter's home nearby so they both went there, where they broke the news of Mr Ireson's death to his mother.

58. The prison's family liaison officer remained in regular contact with the family, although she said she had difficulty in contacting them in the lead up to Mr Ireson's funeral. She wanted to check whether prison staff would be welcome at the funeral but as she did not get a response, no one from the prison attended. The prison contributed to the cost of the funeral, in line with Prison Service instructions.

Support for prisoners and staff

59. The deputy governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The prison's care team also offered support.

60. The deputy governor posted a notice for prisoners informing them of Mr Ireson's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Ireson's death.

Post-mortem report

61. The post-mortem report concluded that Mr Ireson's death was due to hanging. Toxicology results showed no traces of alcohol or illicit substances.

Findings

Identifying and managing Mr Ireson's risk of suicide and self-harm

62. Prison Service Instruction (PSI) 64/2011: *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* sets out the procedures (known as ACCT) that should be followed where a prisoner has been identified as being at risk of suicide and self-harm. It also sets out a list of risk factors and triggers that might increase the risk of suicide and self-harm. Mr Ireson had several risk factors, including a history of deliberate self-harm, a history of mental illness, his offence was against his partner, and he had relationship problems.

63. Staff started monitoring Mr Ireson under ACCT on 22 October, after he told them that he felt under threat on the wing, that he was depressed and felt like slashing his wrists before someone else did. At the first case review two days later, staff stopped ACCT monitoring, because Mr Ireson said he felt okay and staff considered that his crisis period had passed.

64. We consider that staff stopped ACCT monitoring prematurely and an opportunity was missed to put measures in place to support Mr Ireson. We found no evidence that Mr Ireson's risk factors were fully considered or explored during the ACCT process and, although he requested a move to a different wing due to feeling under threat, no one took any action to address this. He remained in the same cell on the same wing when the decision to stop ACCT monitoring was made. He was also still awaiting a mental health assessment. Because ACCT monitoring was stopped at the first case review, no caremap was put in place to try to support Mr Ireson and reduce his risk of suicide and self-harm.

65. The post-closure interview, originally scheduled for 31 October, did not take place until 18 November, almost three weeks late. By that time, Mr Ireson had been moved to a cell on his own, despite previously telling staff that he did not like to be on his own and he wanted to share with someone he could get along with. He remained on B Wing. Mr Ireson had also attended court by videolink and been remanded in prison for a further five months awaiting trial for offences against his partner, but no one was aware of this. A SO did not record anything on the ACCT post-closure interview form to show that she had discussed any of these issues with Mr Ireson. She noted he was not engaging in any activity within the prison and preferred to keep himself to himself.

66. We consider that the ACCT procedures were managed poorly. Mr Ireson's risk factors were not addressed, ACCT procedures were stopped too soon and the post-closure interview was very late and did not properly address what had happened to Mr Ireson since the ACCT had been closed. We make the following recommendation:

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

    - **assess the level of a prisoner's risk based on all available information and known risk factors rather than relying on the prisoner's presentation;**

- **stop ACCT procedures only once they are satisfied that the prisoner's risk has reduced, and record the reasons for the decision;**
- **hold post-closure interviews within seven days of closing an ACCT; and**
- **ensure that the post-closure interview covers the progress the prisoner has made since the ACCT was closed and this is fully recorded.**

67. PSI 07/2015: *Early days in custody* sets out the procedures staff must follow when a prisoner passes through reception, either as a newly arrived prisoner or after a temporary absence, such as attendance at court. All prisoners passing through reception must be assessed for their risk of suicide and self-harm. The PSI acknowledges that some prisoners might bypass reception procedures, for example because their court appearance is by videolink. It says that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by videolink.

68. There is no evidence that anyone spoke to Mr Ireson following his videolink court appearance to assess whether his risk of suicide and self-harm had increased or whether he needed to see healthcare staff. While we accept that there had been no change in Mr Ireson's custodial status in that he had not been convicted or sentenced (a change in custodial status is a known risk factor for suicide and self-harm), he had nevertheless been told that he was to remain in prison for a further five months awaiting trial. We consider that being remanded in prison for a further lengthy period could be a risk factor for suicide and self-harm. We therefore make the following recommendation:

The Governor should ensure that arrangements are in place to identify prisoners who may be at increased risk of suicide and self-harm, or require a healthcare assessment, following a court appearance by videolink.

69. We found that there is little in place to support remand prisoners as they are only allocated an offender supervisor once they have been sentenced. An offender supervisor told us that his primary involvement with Mr Ireson was to get him to sign a non-contact document and his priority was public protection. He said he knew little about Mr Ireson's alleged offence and did not know anything about his court appearance. He said that the OMU offer support for prisoners through drop-in surgeries but agreed that the prisoner would have to be proactive in seeking support. We know that Mr Ireson was someone who preferred to keep himself to himself so we consider he could have benefitted from the kind of support offered by an offender supervisor or keyworker. In the event, as he was a remand prisoner and the keyworker scheme had not yet started, it appeared that no one knew what was going on for Mr Ireson because no one spoke to him about how he was feeling and record keeping was poor.

70. We are aware that all prisoners at Nottingham now have a keyworker and we therefore make no recommendation.

Record keeping, information sharing and support

71. PSI 64/2011 says, “All work and contacts with the prisoner, including healthcare staff, are to be recorded on the NOMIS case recording system, as well as on healthcare systems where appropriate. The principle is that all staff involved with the prisoner share information on risks of harm to self and others.”

72. We found information in Mr Ireson’s NOMIS record to be sparse and important information was not recorded. We consider that a prisoner’s NOMIS record should provide a clear picture of what is going on for them, including activities, risk issues and concerns, court appearances, cell moves, and general entries about progress, achievements and levels of engagement with others. We consider that it is not always enough to simply record information but, at times, some information will need to be followed up or acted upon.

73. For example, one of the few comprehensive entries in Mr Ireson’s NOMIS record was completed by an officer in the safer custody team on the day of reception. Although she noted that Mr Ireson said he struggled with feeling isolated, he went on to spend most of his time in Nottingham in a cell on his own. During the short time he was on an ACCT, Mr Ireson made it clear that he wanted to move from B Wing and he wanted a cellmate that he could get on with, but the ACCT was closed without any of these issues being addressed.

74. Mr Ireson had little experience of being in custody, having been in prison for only one week six years previously. The only contact Mr Ireson had with an offender supervisor was to get him to sign a non-contact order and, as a remand prisoner, it was left to him to be proactive in seeking out someone from OMU if he wanted to discuss his own feelings about his offence and being in prison. When he attended court on 13 November, no one was aware and no one checked on his welfare.

75. During interviews we heard that Mr Ireson was a prisoner who “liked to keep himself to himself” and was very much “under the radar”. However, we consider that there were obvious risk factors for Mr Ireson that, due to poor record keeping and information sharing, were not acted upon to provide him with an appropriate level of support. We therefore make the following recommendation:

The Governor should ensure that staff record all relevant information in prisoners’ records (NOMIS), regardless of their custodial status, in particular:

- **information that may have an impact on prisoners’ wellbeing such as risk information, court appearances, cell moves, and engagement in activities; and**
- **that appropriate follow-up action is taken, as necessary, to offer support to prisoners where such issues have been identified and recorded.**

Mental health

76. When he arrived at Nottingham, Mr Ireson said he had a history of anxiety and insomnia but was not taking any medication. He also said that he had attempted suicide in the past after a previous relationship broke down. The reception screening nurse made a mental health referral on 16 October. A further mental health referral was made as part of the ACCT process on 22 October after Mr Ireson said he felt unsafe on B Wing and was worried this might affect his levels of depression and anxiety. Mr Ireson did not see the mental health triage nurse until 12 November and he said he no longer wanted to engage with the service as he had waited too long.

77. The clinical reviewer said that there were no key performance indicators (KPIs) for mental health assessment waiting times at Nottingham, but the mental health team aimed to see prisoners within five working days. Mr Ireson's assessment with the mental health triage nurse took place after 18 working days. Given that two referrals had been made for Mr Ireson within one week of his arrival, during which time he was also being monitored under ACCT procedures, we would have expected to see a more urgent response to the request for a mental health assessment. We therefore make the following recommendation:

The Head of Healthcare should review the management of the mental health assessment waiting list to achieve the five-day waiting time standard.

Emergency response

78. The OSG who discovered Mr Ireson hanging did not have his cell key on him and had to go to the office to collect it before he could enter the cell. He said this took him no more than twenty seconds and, by the time he returned to the cell, a CM was already using his key to open the cell door.

79. PSI 55/2011: 'Management and Security of Keys and Locks', requires Governors to produce a Local Security Strategy informing staff of their responsibilities when carrying keys. Nottingham's Local Security Strategy requires night staff to keep the cell key, which is in a sealed pouch, with them at all times. The OSG was a relatively new member of staff. He said he was not aware that he should have had the key on his person and we are concerned that other members of staff may also be unaware of this requirement.

80. We are satisfied that the delay in entering Mr Ireson's cell was minimal as the CM arrived and opened the cell while the OSG was at the office collecting his key. However, we are concerned that he was not carrying his cell key and seemed unaware of the requirement to do so. We therefore make the following recommendation:

The Governor should ensure that all staff are aware of Nottingham's Local Security Strategy and PSI 55/2011 on carrying and using cell keys so that they are able to enter a cell in an emergency, without delay.

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