Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Parish a prisoner at HMP The Mount on 21 June 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 Lee Parish was found hanged in his cell at HMP The Mount on 21 June 2017. He was 40 years old. We offer our condolences to Mr Parish's family and friends.

Mr Parish found it difficult to cope in prison because of the breakdown of his relationship and his lack of contact with his children. We are concerned that Mr Parish's risk of suicide and self-harm was not adequately managed, and staff missed ACCT checks a number of times.

It is not the first time that we have identified deficiencies in The Mount's operation of suicide and self harm prevention procedures. The Governor should address these deficiencies urgently.

Given the apparent lack of effective implementation of previous recommendations, we draw this troubling state of affairs to the attention of the Prisons Group Director for London and Thames Valley who will wish to assure himself that effective action is taken.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **June 2018**

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Summary

Events

1. Mr Lee Parish was remanded to HMP Woodhill on 24 August 2016 for robbery and offensive communication. The next day, he was sentenced to nine years in prison. Staff started suicide and self-harm prevention procedures, known as ACCT, after Mr Parish said his mood was low and he was missing his family. He had a history of attempted suicide, anxiety and depression.

2. Mr Parish spent time at a number of prisons before he was transferred to HMP The Mount on 24 April 2017. At an initial health screen, a nurse noted that Mr Parish had been subject to ongoing ACCT procedures and had a history of attempted suicide and overdose. She noted that he was not taking any medication. She referred him to a prison GP and the mental health team. Prison staff stopped ACCT monitoring two days later.

3. On 8 May, the prison GP prescribed antidepressants for Mr Parish after he said his mood was low. Prison staff gave Mr Parish telephone credit on compassionate grounds a number of times because he had no money and wanted to speak to his ex-partner and family. (A restraining order was in place which prohibited Mr Parish from contacting his ex-partner.)

4. On 25 May, a member of the chaplaincy started ACCT procedures when Mr Parish said that he felt depressed and suicidal. Prison staff did not complete his first ACCT review until three days later and no one from the healthcare team attended either this review or subsequent ones.

5. On 11 June, staff found Mr Parish with a noose that he had earlier removed from his neck. Staff did not complete an ACCT review after this incident or refer Mr Parish to the healthcare or mental health team. On 19 June, Mr Parish told staff that his mood was low and that he felt on the verge of a nervous breakdown. Staff increased Mr Parish's ACCT observations to hourly.

6. On 21 June, staff unlocked Mr Parish's cell at about 1.45pm but did not speak to him or look through the observation hatch to check his wellbeing. At 3.25pm, a prisoner found Mr Parish hanged from a ligature made from torn sheets. The prisoner pressed the general alarm button and alerted staff. Staff attended and radioed a medical emergency code, and the control room called an ambulance immediately. Staff tried to resuscitate Mr Parish. When the paramedics arrived, they took over his care but at 4.10pm, they recorded that Mr Parish had died.

7. Mr Parish's ACCT record noted that staff had last checked on him at 12.20pm. This was not the first time that staff had failed to complete hourly ACCT checks for Mr Parish, as they should have done.

Findings

ACCT procedures

8. Staff appropriately assessed Mr Parish as at risk of suicide and self-harm. While they monitored him under ACCT procedures, there were a number of

deficiencies in the way they did so and clear failures to comply with Prison Service policy.

9. Safer custody checks were not carried out with the required frequency. We were told, and it was hard not to agree, that reduced staffing levels and conflicting priorities impacted on staff's ability to carry out appropriate checks.

Unlock procedures

10. No one checked on Mr Parish's wellbeing on 21 June 2017 when his cell was unlocked after lunch or completed his hourly ACCT checks, as required.

Non-compliance with restraining order

11. With misdirected good intentions, staff undermined a restraining order by allowing Mr Parish to contact his ex-partner on more than one occasion. This caused his ex-partner distress.

Clinical care

12. The clinical reviewer found that Mr Parish's clinical care was not equivalent to that which he could expect to receive in the community. Healthcare staff did not contribute to the management of Mr Parish's risk of suicide and self-harm.

Recommendations

- The Prisons Group Director for London and Thames Valley Prisons should assure himself that effective action is taken to implement recommendations from this and previous investigations into deaths at HMP The Mount.
- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
    - Holding a multidisciplinary case review within 24 hours of an ACCT plan being opened and when there is evidence of significant change in risk.
    - Prison and healthcare staff working jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review.
    - Holding multidisciplinary ACCT reviews, with continuity of case management and involving all staff who can contribute to a prisoner's care.
    - Case managers completing caremaps at the first ACCT case review, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.
    - All staff undertaking ACCT observations as directed and actively engaging with prisoners being monitored.
- The Governor should ensure that when staffing on a unit is reduced, arrangements are in place to ensure that prisoners subject to ACCT procedures are appropriately and formally monitored.

- The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the prisoner’s wellbeing and that there are no immediate issues that need attention.
- The Governor should ensure that effective measures are in place to address public protection issues before allowing a prisoner access to all telephone numbers.

The Investigation Process

13. The investigator issued notices to staff and prisoners at The Mount, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded but later refused to speak to the investigator.

14. The investigator visited The Mount on 29 June 2017, and obtained copies of relevant extracts from Mr Parish's prison and medical records.

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

16. The investigator interviewed 12 members of staff at The Mount in August and September 2017. The interviews with healthcare staff were conducted jointly with the clinical reviewer. The investigator identified three prisoners he wanted to interview but they refused to speak to him.

17. We informed HM Coroner for Hertfordshire of the investigation. We have sent the Coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted and visited Mr Parish's family to explain the investigation. Mr Parish's ex-partner and sister-in-law asked a number of questions which we have dealt with in separate correspondence.

19. Mr Parish's family received a copy of the initial report. The solicitor representing them wrote to us and raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP The Mount

20. HMP The Mount is a medium security prison holding approximately 1,000 men. Hertfordshire Community NHS Trust provides primary healthcare services and GP services. There are daily GP sessions from Monday to Friday, with out of hours provision at other times. No healthcare staff are on duty between 6.30pm and 8.00am. Mr Parish lived on Lakes Wing which has four spurs with two landings.

HM Inspectorate of Prisons

21. The most recent inspection of The Mount was in April 2015. Inspectors reported that The Mount generally managed prisoners at risk of suicide and self-harm adequately but lessons from previous deaths had not been fully implemented. Most prisoners said that staff treated them respectfully but were very busy. Inspectors found that the mental health in-reach team provided a good level of secondary mental healthcare but primary mental health services were inadequate.

Independent Monitoring Board

22. 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 most recently published report for the year to February 2017, the IMB noted that in the summer of 2016, The Mount were at risk of disorder (as has previously been experienced in other prisons) due to staff shortages, readily available drugs and mounting violence. The Mount had struggled with staff shortages and experienced staff had left without being replaced so that by the end of February 2017, there were 24 vacancies out of a total of 136 officers. The IMB noted that a high proportion of officers and managers had less than two years' experience.

23. The IMB said that staff shortages had led to staff who should have worked in the Offender Management Unit, working on wing duties instead. This meant that they were unable to offer guidance to prisoners. They noted that wing staff were extremely busy and moved frequently from wing to wing. This meant that they found it difficult to get to know the prisoners for whom they were responsible.

Additional information

24. There was a major disturbance at The Mount on 31 July 2017 when prisoners took control of two wings, including Lakes Wing, where Mr Parish had lived.

Previous deaths at HMP The Mount

25. Mr Parish was the fourth prisoner to take his life at The Mount since August 2015. Two prisoners died of natural causes over the same period. The findings in two of our investigations identified deficiencies in the operation of suicide and self-harm prevention procedures.

Assessment, Care in Custody and Teamwork

26. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT 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. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Restrictions on the communications of prisoners subject to restraining orders

27. Chapter 6 of HMPPS's Public Protection Manual requires Governors to identify all prisoners who are convicted of harassment offences or are subject to a restraining order. Such prisoners must be issued with a notice informing them that they must not contact or attempt to make contact with anyone named in a restraining order. Prisoners subject to these procedures will only be permitted to have telephone numbers that have been approved by the prison on their Pin phones.

28. Prison Service Instruction (PSI) 49/2011 (Prisoner Communication Services) says that prison staff must be familiar with the procedures and restrictions that apply to prisoners who are subject to a restraining order.

Key Events

Background

29. On 28 May 2016, Mr Lee Parish was remanded to HMP Woodhill for robbery and offensive communication (threats of violence to his former partner). This was his first time in prison. At his reception screening, staff identified that he had a history of suicide and self-harm. Mr Parish said that he had no currents thoughts of suicide or self-harm and no history of substance misuse or mental ill health. A mental health nurse saw him and noted that his mood was low because of family issues.

30. On 27 June, Mr Parish was bailed and on 14 July, he was voluntarily admitted to a mental health hospital after he took an overdose. The next day, he discharged himself against medical advice. On 14 August, Mr Parish went to hospital after he took an overdose of antidepressants and drank three cans of cider. By travelling to hospital, Mr Parish had breached the terms of his bail and the police subsequently arrested him.

31. On 24 August, Mr Parish was sent back to HMP Woodhill, where staff completed a full reception screening. The prison GP prescribed citalopram (an antidepressant). The next day, Mr Parish attended court and was sentenced to nine years in prison.

32. On 26 August, staff started ACCT procedures after Mr Parish admitted that his mood was low. He said that he had split from his partner and he had expected to receive a sentence of three years. Staff stopped ACCT monitoring on 8 September.

33. On 20 September, Mr Parish was transferred to HMP Stocken. On 18 October, the doctor stopped prescribing citalopram because Mr Parish's medical records noted that he had not been collecting it.

34. On 19 October, Mr Parish was transferred to HMP Exeter, where staff recorded that a restraining order prohibited him from contacting his ex-partner.

35. On 3 November, Mr Parish was transferred back to Stocken. At the end of November, Mr Parish became more anxious and the prison GP prescribed mirtazapine (an antidepressant). On 19 December, staff started ACCT monitoring after Mr Parish alleged that he had taken an overdose of mirtazipine. A mental health nurse noted that Mr Parish was struggling with being apart from his family at Christmas. Mr Parish refused medical intervention and told staff that he would not harm himself. Healthcare staff decided that Mr Parish should no longer be allowed to keep his medication but instead, staff should dispense it to him. On 28 December, staff stopped ACCT monitoring.

36. On 4 January 2017, the prison GP stopped Mr Parish's mirtazapine because he had not collected it. That day, staff started ACCT procedures again after Mr Parish expressed suicidal thoughts and monitored him until 20 January. Mr Parish told staff that other prisoners had threatened him and so he had refused to leave the wing to collect his medication. Staff moved Mr Parish to another

wing and reported that he had settled. Mr Parish told staff that he did not require any medication.

37. On 9 February, staff at Stocken submitted an intelligence report which noted that Mr Parish had tried to contact his ex-partner more than once despite having a restraining order. He had also asked a number of times for phone credit on compassionate grounds to contact his family.

March 2017 - April 2017

38. On 13 March, Mr Parish was transferred to Woodhill. Staff started ACCT procedures immediately after he said that his "head was all over the place" and his mood was low. However, staff stopped ACCT monitoring the next day, and noted that Mr Parish had settled and had no thoughts of suicide or self-harm.

39. On 21 March, Mr Parish told staff that he would kill himself as he had not seen his children for some time, was unable to contact his ex-partner and felt helpless. He said he was depressed because someone had stolen his tobacco. He said that he was, however, looking forward to his father and two brothers visiting him. Staff started ACCT procedures and made an appointment for Mr Parish to see the prison GP because of his depression. Mr Parish did not attend the appointment.

40. On 27 March, staff completed an ACCT review. Mr Parish presented slightly more positively but said that his son was ill in hospital and this added to his low mood. He said staff had facilitated calls to his family as he had no PIN phone credit or money. Mr Parish said he had no thoughts of suicide or self-harm.

41. On 4 April, Mr Parish attended an appeal court hearing by video link. The court reduced his prison sentence from nine to six years. Staff completed an ACCT review immediately afterwards. Mr Parish was in shock and tearful at the appeal outcome as he had expected an earlier release from prison. He said he had thoughts of suicide and would feel better if he could speak to his children but had no PIN phone credit. He said he had problems sleeping. Wing staff telephoned Mr Parish's brother who confirmed that Mr Parish's son was okay. They passed this information to him. Afterwards, the prison GP prescribed medication to help Mr Parish sleep better.

42. At the next ACCT review on 5 April, staff recorded that Mr Parish felt better about the outcome of his appeal. Mr Parish said he wanted to transfer to a category D prison (an open prison) so that he could resume contact with his children. He hoped to re-establish his relationship with his ex-partner and have his restraining order lifted. The review panel set Mr Parish's observations at two conversations a day and five observations at irregular times at night.

43. On 6 April, staff gave Mr Parish a warning because he had breached his restraining order by contacting his ex-partner twice in one day. Mr Parish said he was struggling in prison because he was not allowed to communicate with her.

24 April 2017 - June 2017 (HMP The Mount)

44. On 24 April, Mr Parish was transferred to The Mount. At his initial health screen, a nurse noted that Mr Parish was being monitored by ACCT and had a history of

attempted suicide. Mr Parish told the nurse he had no current thoughts of suicide or self-harm, no current substance misuse problems and had previously been prescribed antidepressants. The nurse referred Mr Parish to the prison GP and primary mental health team, and noted his low mood and depression.

45. Mr Parish was located on Nash Wing, the induction unit, where he shared a cell with another prisoner. A member of the chaplaincy team, saw Mr Parish as part of his induction. Mr Parish told him that he sometimes got angry. The member of the chaplaincy team, noted that he had referred Mr Parish for counselling. (While at the Mount, Mr Parish was not seen by a counsellor.) On 25 April, staff facilitated a phone call to Mr Parish's brother because he had no phone credit.

46. On 26 April, the Supervising Officer (SO) chaired an ACCT review, assisted by, a member of the chaplaincy team. No one from the healthcare team attended. Mr Parish said that he was keen to progress through the prison system to achieve his category D status. He felt much better and positive about resolving his family issues and said he no longer needed to be supported by ACCT procedures. The review panel assessed that he was no longer in crisis and stopped ACCT monitoring.

47. On 3 May, a SO completed a post-closure ACCT review. The SO had no concerns about Mr Parish and the ACCT remained closed. On the same day, staff approved an application from Mr Parish for £5 PIN phone credit on compassionate grounds so that he could speak to his family (his father, brother and son).

48. The next day, Mr Parish told a member of the chaplaincy team, that he had family issues and it had been the anniversary of his mother's death the day before. He offered Mr Parish support and facilitated a phone call to his brother. Later that day, Mr Parish spent some quiet time in the chapel.

49. On 8 May, a prison GP, saw Mr Parish. Mr Parish said his mood was low, he felt tired and depressed. He had thoughts of suicide but had no intention to act on these because of his family. He was missing his children and wanted to be moved to a category D prison. The prison GP noted Mr Parish interacted well. He prescribed citalopram and agreed to review Mr Parish in three weeks.

50. On 17 May, staff approved compassionate PIN phone credit of £2 for Mr Parish.

51. On 18 May, a mental health nurse, assessed Mr Parish. Mr Parish told her that he was adjusting to prison life but was struggling to cope with his relationship breakdown and he had not seen his two children since August 2016. Mr Parish said he had thoughts of suicide but had no intention to act on these. He hoped his recently prescribed medication would take effect soon. The nurse discussed relaxation and sleep techniques with Mr Parish.

52. On the morning of 25 May, staff again approved compassionate PIN phone credit of £2 for Mr Parish. He asked staff if he could speak to a member of the chaplaincy team. A member of the team visited Mr Parish on the wing at around 12.30pm. Mr Parish told him that he felt depressed, suicidal and found it difficult to cope without his family. He was also not happy sharing a cell and wanted to move.

53. A member of the chaplaincy team started ACCT procedures. Prison staff set Mr Parish's observations at twice an hour until his ACCT assessment and first review were completed. Staff noted that they had referred Mr Parish to the mental health team and would facilitate a phone call to his family.

54. At 2.00pm, an SO assessed Mr Parish under ACCT procedures. He recorded that Mr Parish's mood was low. Mr Parish said he missed his family but would not harm himself. The SO discussed counselling and speaking to the chaplaincy for support. Mr Parish said he wanted to complete a course on family links and improving relationships. Mr Parish told staff again that he wanted to move cell stating he did not get on with his cell mate.

55. On 28 May, the SO chaired the first ACCT review with an officer. No one from the healthcare team attended. The SO told the investigator that he had been away form the prison for a few days and when he returned, he found that Mr Parish's first case review had not been completed as it should have been. He completed the review immediately to avoid further delay.

56. Mr Parish told the review panel that his mood was low because he missed his children. While he said he welcomed the support, he felt the observation level was too high. The review panel noted that Mr Parish's risk of self-harm was low and reduced his observation to one conversation three times a day. The SO set the next review for 3 June.

57. Although undated, the SO noted three issues in Mr Parish's caremap. He recorded that he intended to ask the activities' department whether Mr Parish could be assigned a job; wing staff would speak to the chaplaincy to see if they could offer him counselling; and Mr Parish had asked for a possible transfer to HMP Peterborough. He told Mr Parish to submit a transfer application.

58. At interview, the prison GP said that he was unaware that staff had started ACCT procedures for Mr Parish. He said that if he had known, he would have changed his medication prescription to not in-possession to reflect his increased risk. The prison GP said he expected to review Mr Parish at a scheduled appointment on 30 May. A nurse was due to see Mr Parish on 1 June. Mr Parish did not attend either appointment and staff recorded no reason for this.

59. Mr Parish attended the chapel on the morning of 3 June and spoke to a member of the chaplaincy team. Mr Parish was concerned about his son but said his family situation had started to look more optimistic. He said he had spoken to his ex-partner – there is no evidence to say how he had done this. He said this meant a lot to him and his brother had also been supportive. Mr Parish said he found it difficult to cope on the wing, particularly because of the noise.

60. On 5 June, the SO chaired the second ACCT case review, and an officer attended. No one from the healthcare team attended. Mr Parish said he was worried about his son who had recently had an operation. He said he had attended church earlier that day and a member of the chaplaincy had suggested that staff facilitate a phone call for him because his other son had gone missing. The SO was unsure how Mr Parish knew this or whether they were genuine issues. Nonetheless, he agreed that staff would facilitate a phone call for him to his family. The SO made no change to Mr Parish's observation level or noted his

current risk of suicide or self harm. He set the next case review for 14 May (although he was likely to have meant 14 June).

61. The next day, Mr Parish participated in activities and attended an education class.

62. On 9 June staff moved Mr Parish to a single cell on Lakes Wing. He told a member of the chaplaincy team the next day that he had recently had a good visit from his brother.

63. At 4.55pm on 11 June, staff noted that they had facilitated a phone call to Mr Parish's family because his son had been taken to hospital. At around 7.45pm, staff responded to Mr Parish's cell bell and found him with a noose in his hand. Mr Parish gave staff the noose, said he was upset and had family issues. A custodial manager, noted that staff had given Mr Parish a breakfast pack and he had used a Listener (a prisoner trained by the Samaritans to provide support to other prisoners). Staff increased Mr Parish's ACCT observations to twice an hour. At 9.00pm, the night patrol officer, checked on Mr Parish who said he was now okay. No ACCT review took place after this incident.

64. On the morning of 12 June, Mr Parish told staff that his mood had improved and he felt better. Staff facilitated a phone call to his brother and approved his application to have £2 of PIN phone credit for compassionate reasons.

65. At midday, Mr Parish spoke to a custodial manager, about his recent act of self-harm. She noted that Mr Parish said he still felt some neck pain from the ligature. She noted that the nurse would see Mr Parish that afternoon. Mr Parish said he was concerned about his ill son and this added to his risk of self-harm. He asked if staff could keep a closer eye on him because he felt stressed. She noted that staff had approved a smoker's pack for him and she increased his ACCT observations to three per hour. There is no evidence that healthcare staff saw him that day or knew about the incident.

66. When staff initially unlocked Mr Parish on the morning of 14 June, he said his mood was low because of his son. At 9.00am, Mr Parish asked for a compassionate phone call to his family because his son was in hospital. At 10.45am, staff escorted Mr Parish to the chapel to speak to a member of the chaplaincy team. He said Mr Parish appeared agitated when he spoke about his son. He facilitated phone calls for Mr Parish to his ex-partner, brother and father. He told the investigator that he was unaware that Mr Parish had an active restraining order which prohibited him from contacting his ex-partner.

67. When Mr Parish returned to the wing, he submitted an application to transfer to HMP Peterborough. Staff moved Mr Parish to another spur on Lakes Wing, where he shared a cell with another prisoner.

68. At 2.05pm, a SO held an ACCT review with a member of the chaplaincy team. (She noted that this was Mr Parish's second case review, although it was his third.) She noted that Mr Parish's cellmate was a loud character and that Mr Parish should be located in a single cell. Mr Parish said that a family friend had been interfering and trying to ruin his relationship with his ex-partner and he wanted to speak to the police liaison team about this. He said that staff in the chaplaincy had facilitated phone calls for him to members of his family and wing

staff had given him a smoker's pack. Despite this, Mr Parish said his mood was still low.

69. The SO noted that there was no change to Mr Parish's risk of self-harm. She did not change his observations but reduced his night observations to three during this period. She updated the caremap, and noted that Mr Parish had been allocated work, he had submitted a transfer application and a member of the chaplaincy team had asked for him to receive counselling. She added three further issues to the caremap. These were that she had sent an email to another SO who was Mr Parish's offender supervisor, asking for details about his sentence; she noted that staff should contact the police liaison officer about Mr Parish's concerns; and that Mr Parish should relocate to a single cell. Staff recorded no further concerns about Mr Parish for the rest of the day.

70. A SO told the investigator that he was Mr Parish's offender supervisor and had worked in the Offender Management Unit (OMU) since February 2017. He said that he could not undertake his role as he was constantly working on wings because of the low staffing levels. He had therefore had no contact with Mr Parish or any other prisoner for whom he was responsible.

71. On the morning of 15 June, Mr Parish asked an officer if he could see a member of the chaplaincy team.

72. On 16 June, Mr Parish told an officer that his brother had received messages from someone demanding money. The officer facilitated a phone call to Mr Parish's brother. That day, staff relocated Mr Parish's cellmate and Mr Parish was left alone in his cell. The next day, Mr Parish again asked staff if he could see the chaplaincy team. The officer said he would try to arrange this.

73. On 18 June, Mr Parish told an officer during an ACCT check that his mood was low. He declined the offer to see a Listener and so the officer tried to contact the chaplaincy team. At 5.40pm, Mr Parish told another officer that his "head was all over the place" as he had not been able to make a phone call. (Although the officer could not recall, he said that this might have been one of the times that he facilitated a phone call to Mr Parish's ex-partner.) When he checked an hour later, Officer O'Farrell noted that Mr Parish was in a better mood.

74. On 19 June, Mr Parish did not attend work. At around 2.30pm, an SO chaired an ACCT review and a member of the chaplaincy team attended. Mr Parish said that his mood was low and he felt like he might have a nervous breakdown. He said that this feeling worsened at night. An SO tried to reassure Mr Parish that staff would help him. He told Mr Parish that he would refer him to the mental health team and told him that staff had already sent his earlier concerns to the police liaison team. The SO told the investigator that by the end of the review, Mr Parish's mood was much more positive.

75. An SO increased Mr Parish's observations to hourly at all times, and noted that staff should have three conversations with him during the day. He facilitated a phone call for Mr Parish to his family. Staff again approved an application from Mr Parish to receive £2 of PIN phone credit for compassionate reasons. Mr Parish telephoned his son and his brother twice that afternoon. In the last phone

call to his brother at 5.57pm, Mr Parish asked about his ex-partner. Mr Parish's brother told him not to worry.

76. Although an SO had increased Mr Parish's ACCT observations to hourly, staff only checked Mr Parish six times (out of a total of 11 required checks) until 20 June. Mr Parish was checked at 8.33pm and 11.03pm on 19 June and then at 2.18am, 3.22am, 5.50am and 8.00am on 20 June.

20 June

77. When staff unlocked Mr Parish at 8.00am, he did not go to work. Mr Parish told a SO that he was unsure what was required of him and did not feel good. The SO explained the benefits of work and keeping himself busy. He contacted the chaplaincy team and asked if they could see Mr Parish that day. Mr Parish used his PIN phone account and called his brother at 11.18am and 11.38am. During their conversations, Mr Parish asked his brother to contact the prison and say that he was worried about his state of mind. Mr Parish said he hoped this might influence the governors to transfer him to another prison. Despite a requirement for hourly observations, staff made no entries in Mr Parish's ACCT record between 9.15am and 12.15pm.

78. A member of the chaplaincy team, spoke to Mr Parish at around 12.15pm. Mr Parish told her that he was missing his children and ex-partner. He talked about his ex-partner and hoped their relationship had not ended. He said he had pictures of her that lifted his mood. His ex-partner and children had not visited him but he had managed to write and speak to them by phone. Mr Parish said he intended to be more positive, keep himself busy and would attend work the next day. She facilitated a phone call to his brother.

79. Mr Parish used his PIN phone account to contact his sister at 5.16pm. He left a message on her answerphone, which asked his sister if "she" – he was likely referring to his ex-partner - had got back to her as he was worried. Staff carried out the required hourly ACCT checks for the rest of the evening and night.

21 June

80. After staff unlocked him, Mr Parish made a phone call from his PIN account to his sister at 8.11am. Mr Parish again asked if his ex-partner was okay and whether his sister had heard from her. His sister said that she was sure she was okay. Mr Parish said he had been "shaking" all night. He wanted confirmation that his ex-partner would give him a chance. His sister reassured him and said that his partner would not say it if she had not meant it. Before ending the call, Mr Parish asked his sister to check this for him and said he would phone her back later.

81. An officer recorded in the ACCT record at 8.40am that Mr Parish attended the wing office and asked to speak to the chaplaincy team.

82. Mr Parish made a short phone call from his PIN account to his brother at 8.52am. He said he only had ten pence of phone credit left. Mr Parish's brother told him that his ex-partner had texted him about a BMX bike for his (Mr Parish's) son.

83. A SO said he had a long conversation with Mr Parish in the wing office later that morning to check on his wellbeing. Mr Parish said he had some questions to ask

about his prison sentence and spoke about his son who was ill in hospital. He told Mr Parish that staff would support him whenever he needed it. He said he would contact the chaplaincy to arrange an appointment for Mr Parish and would discuss his sentence concerns with him later. The SO phoned the chaplaincy team and made an appointment for Mr Parish to see a member of the chaplaincy team at 1.45pm. The SO told Mr Parish that he would ensure staff unlocked him after lunch to attend his appointment. The SO was on duty in another part of the prison that afternoon.

84. Afterwards, Mr Parish returned to his cell and staff locked all prisoners who were not attending activities back into their cells.

85. The prison GP told the investigator that the pharmacist told him that morning that Mr Parish had not been collecting his medication. He did not say for how long he had not collected it. The prison GP stopped prescribing it and noted that he would make an appointment to see Mr Parish.

86. CCTV footage showed that Mr Parish pressed his cell bell at 10.40am. An officer (who was on sick leave during our investigation) responded 15 minutes later. This was not in line with HMIP's expectation that staff should respond to cell bells within five minutes.

87. At about 11.03am, an officer started unlocking cells on Mr Parish's landing. He did not look through Mr Parish's observation panel when he unlocked the door. Mr Parish left his cell within a couple of minutes. For the next hour, CCTV footage showed Mr Parish leaving his cell several times for short periods, walking up and down and leaving the landing.

88. In his police statement, Mr Parish's former cell mate, said that during the lunch period, Mr Parish had come to his cell and asked if he knew where to buy a mobile phone. He said no and Mr Parish left. An officer recalled seeing Mr Parish collect his lunch between 11.30am and 11.45am from the kitchen servery. They had a brief conversation in which Mr Parish said he was okay.

89. At 12.12pm, Mr Parish used the PIN phone and called his brother. He said he had 11 pence phone credit and so their conversation would be short. Mr Parish's brother said that he had received a text from someone who had asked for £140. Mr Parish denied knowing who this was. Mr Parish asked his brother if the “text” earlier was okay and asked if he had anything to worry about. Mr Parish's brother said no, “she” only mentioned Mr Parish's son and his bike.

90. Afterwards, CCTV footage showed Mr Parish standing in his cell doorway, talking to a staff member from the chaplaincy team. He told the investigator that he had visited Mr Parish at the request of an SO to check on his welfare. While talking to Mr Parish, the member of the chaplaincy team noticed that it was dark inside his cell because a sheet covered the window. He encouraged Mr Parish to go outside to get some fresh air. Mr Parish said he was okay and planned to attend the chapel that afternoon. He said he had no concerns about Mr Parish.

91. In their police statements, two prisoners, said they saw Mr Parish standing on the landing just before staff started locking prisoners in their cells. They had no concerns about Mr Parish. At 12.20pm, an officer looked through Mr Parish's

door observation panel to check on him and locked his cell door during the roll check count. He recorded that Mr Parish appeared asleep on his bed. (This was the last ACCT check recorded before Mr Parish was found hanged in his cell.)

92. At 1.00pm, another officer recorded in Mr Parish's ACCT record that he had an appointment in the chapel at 1.30pm. There were no further entries in the ACCT record.

93. Slightly later than usual at around 1.45pm, the control room gave permission for staff to unlock prisoners who attended activities. Four members of staff were initially on duty on Lakes Wing that afternoon and the SO was covering Lakes Wing and Ellis Wing. An officer unlocked prisoners on A spur and then assisted another officer to unlock prisoners on B spur and to manage prisoners leaving the wing. A third officer unlocked prisoners on C spur after which he went to work in the education unit. A fourth officer unlocked prisoners on D spur (where Mr Parish lived) and then went to work in the visits area.

94. Although the officer unlocking prisoners on D spur, knew about Mr Parish's appointment with the chaplaincy, CCTV footage confirmed - and he admitted - that when he unlocked Mr Parish's cell at around 1.45pm, he did not look through the door observation panel or speak to him before unlocking the next cell. The officer said that he was under pressure to unlock the spur as quickly as possible. He said that prisoners also asked him a number of questions as they were unlocked.

95. The officer and a colleague left Lakes Wing immediately after unlocking their respective spurs. An SO was carrying out duties in another part of the prison. Two officers had supervised prisoners leaving the wing by about 2.25pm and had closed the wing gate. An officer then escorted a prisoner to the healthcare unit. When he returned, the second officer escorted another prisoner to the Care and Separation Unit for a disciplinary hearing. He returned to the wing just before 3.00pm in time for the 3.00pm movements, when prisoners return to the wing from education classes and workshops.

96. At around 3.00pm, two SOs both phoned the officer on Lakes Wing. The SO said that arrangements had been made for Mr Parish to be moved to Fowler Wing that afternoon. He said that the Governor had asked for an immediate target cell search on A spur and staff were needed for this. The officer said he tried to explain to the SO the difficulties a target search would cause as there were only two officers on the wing who had to unlock prisoners and complete security checks on time. The officer said the SO arrived on Lakes Wing at about 3.15pm and the two officers continued this discussion.

Emergency response

97. Mr Parish's cellmate said that he checked on Mr Parish at 3.25pm. He pushed Mr Parish's cell door open and found him hanging from a low metal bracket attached to the wall at the end of the cell. Mr Parish's legs were in front of him, his head was facing down slightly, he was grey in colour and his eyes were closed.

98. The cellmate ran out of the cell, shouted for help, and pressed the general alarm button (recorded in the control room log as occurring at 3.25pm). Three prisoners ran into the cell and supported Mr Parish's weight while they unhooked his body from the wall and moved him to the cell floor. Another prisoner, tried to remove the ligature from around Mr Parish's neck but it was too tight.

99. From the wing office, the officer and the SO heard the general alarm and the commotion of prisoners shouting, "He's dead". They responded immediately. CCTV footage shows that two SO's, and two officers arrived within 20 seconds of the alarm being called. The officers went into the cell and saw Mr Parish slumped on the floor, with a ligature made from bed sheets around his neck. The prisoners left Mr Parish's cell and staff took over his care.

100. An SO cut the ligature from around Mr Parish's neck. The officer checked Mr Parish's vital signs, but found none. He started cardiopulmonary resuscitation (CPR) by doing chest compressions. The second SO immediately radioed a medical emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing) at 3.26pm. The control room called an ambulance immediately. The SO collected the defibrillator from the wing office and returned to the cell within a minute. Another officer assisted with chest compressions. CPR continued until two nurses arrived at 3.29pm and took over Mr Parish's care. Staff moved Mr Parish onto the wing landing to create more space. Mr Parish remained unresponsive. Paramedics arrived at Mr Parish's cell at 3.41pm. An air ambulance doctor also arrived and examined Mr Parish. At 4.10pm, the paramedics and doctor pronounced that Mr Parish had died.

101. Staff found a letter in Mr Parish's cell which he had written to his ex-partner. In the letter, he said that he intended to take his own life.

Support for prisoners and staff

102. The duty governor, briefed staff involved in the emergency response and offered his support and that of the staff care team. Staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by Mr Parish's death, and offered support.

Contact with Mr Parish's family

103. Two prison managers were appointed as family liaison officers (FLO). Prison records had recorded Mr Parish's brother and ex-partner as his next of kin. The family liaison officers visited Mr Parish's brother at around 5.45pm but he no longer lived at the address. They visited Mr Parish's ex-partner at around 7.30pm. They explained what had happened and offered support.

104. Mr Parish's ex-partner told the family liaison officers that she had received phone calls from Mr Parish, facilitated by chaplaincy staff. She was surprised as there was a restraining order in place to prevent Mr Parish from contacting her. She also received a phone call on her mobile phone from an unknown mobile number while the family liaison officers were with her. She answered the call, quickly became distressed and passed her phone to the prison FLO. The caller identified himself and said he was Mr Parish's cellmate (although Mr Parish had no cellmate at the time). He said that he had called her to ensure that she was

aware Mr Parish had died. The FLO explained to the caller that Mr Parish's ex-partner was unable to talk to him and ended the call. The second FLO noted the mobile phone number and passed this information to the duty governor.

105. Mr Parish's ex-partner provided the telephone contact details for Mr Parish's brother. She did not know his address. The FLO phoned Mr Parish's brother that evening, explained what had happened and offered support. On 22 June, both FLOs visited Mr Parish's brother but no one was there. Afterwards, they visited Mr Parish's ex-partner again.

106. On the morning of 23 June, the FLO phoned Mr Parish's ex-partner who was upset after receiving some letters from Mr Parish in the post that morning. Mr Parish had apparently used another prisoner's name and prison number to get the post through prison security checks. That day, both FLOs also visited Mr Parish's brother.

107. Mr Parish's funeral was held on 6 July and in line with Prison Service policy, the prison contributed to the costs. The prison held a memorial service and invited Mr Parish's next of kin and members of his family to attend.

Cause of death

108. A post-mortem examination concluded that Mr Parish died from asphyxiation. Toxicology results found no illicit substances in Mr Parish's system.

Findings

Management of risk of suicide and self-harm

ACCT assessment and reviews

109. Prison Service Instruction (PSI) 64/2011 requires a multidisciplinary approach for ACCT case reviews, with relevant people involved in the prisoner's care, and a continuity of case manager. Where possible, healthcare staff should attend the first review. It says that a case manager should hold a first ACCT case review within 24 hours of starting ACCT monitoring, ideally immediately after the assessment interview, with the assessor present.

110. This did not happen. An SO chaired the first ACCT review on 28 May, three days after ACCT monitoring started. As the assessor, it was inappropriate for the SO to chair the first case review but he said that a case manager had not been assigned due to staff shortages. There was no input from the healthcare team at the review and the four case reviews were chaired by different managers.

111. The PSI states that staff should decide at the first case review whether to refer someone for mental health or substance misuse support services and ensure the referral(s) are made. Mr Parish had been prescribed antidepressants on 8 May but there was no input from the mental health team at the first review nor was he referred to them for additional support. Healthcare staff told the investigator that they were not always made aware that a prisoner was subject to ACCT monitoring or invited to first or subsequent ACCT reviews.

112. In addition to planned case reviews, the PSI requires staff to hold a case review as soon as possible if a trigger for suicide or self-harm is activated or if they are concerned about the prisoner at risk. Although staff increased Mr Parish's ACCT observations when they found him with a noose in his cell, we are concerned that no one held an ACCT case review or discussed the incident with Mr Parish subsequently. Staff also failed to refer Mr Parish to the healthcare and mental health team after this incident.

Healthcare input

113. When Mr Parish arrived at The Mount on 24 April, healthcare staff recorded in his medical record that he was being monitored under ACCT procedures. However, they did not contribute to managing Mr Parish's risk of suicide and self-harm and they did not refer to the ACCT reviews noted in his medical record. Healthcare staff never attended any case reviews. The prison GP said he would have reviewed Mr Parish's prescribed antidepressants if he had been told that staff were monitoring him under ACCT procedures. Healthcare staff confirmed that prison staff gave them a daily list of prisoners who were subject to ACCT monitoring. We are concerned that this information was not used effectively to manage prisoners' risk.

Caremaps

114. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the

ACCT assessment interview. They must be tailored to meet prisoners' individual needs and reduce risk. They must be time bound and say who is responsible for completing the action. Staff failed to update issues identified from the first case review on Mr Parish's caremap until 14 June, the third case review.

115. Staff also failed to recognise and include in the caremap how important it was to Mr Parish to have contact with his ex-partner and family regularly, and that this affected his behaviour, thinking and risk and needed to be considered in light of the restraining order.

116. Staff approved Mr Parish's numerous applications for compassionate PIN phone credit while simultaneously granting him access (from an official phone) to make phone calls to his family and (wrongly) to his ex-partner. While on the one hand, this indicated that most staff had a caring approach, there was no co-ordinated plan to manage Mr Parish's risks and potentially manipulative behaviour or the implications for his ex-partner. Staff failed to set and record clear and effective actions aimed at addressing Mr Parish's communication issues with his family in the caremap, despite knowing these issues affected his risk of suicide and self-harm.

117. An uncoordinated approach also meant that some staff unknowingly enabled Mr Parish to breach the restraining order by allowing him to contact his ex-partner on more that one occasion.

118. Although staff recorded that Mr Parish should be considered for counselling when he arrived at The Mount and also at the first ACCT review, on the caremap, there was no follow up on this proposed action or information on whether it had actually been arranged.

ACCT checks

119. From the afternoon of 19 June, Mr Parish's agreed level of ACCT observations required that he should be checked at least once an hour. Staff however failed to adhere to hourly checks on more than one occasion. For example, from the evening of 19 June through to the morning of 20 June, staff only checked Mr Parish six times (out of a required total of 11) over a 12-hour period. Checks occurred at 8.33pm, 11.03pm, 2.18am, 3.22am, 5.50am and 8.00am. On 21 June, staff again showed inconsistency when completing the hourly ACCT checks. Staff recorded that they checked Mr Parish at 8.40am, followed by a check at 9.50am with the next and last check occurring at 12.20pm. Staff subsequently discovered Mr Parish hanged in his cell at 3.25pm.

120. ACCT observations are intended to ensure the wellbeing of prisoners and offer them support as needed. The level of observation is agreed at a case review according to a prisoner's level of risk. The PSI says that conversations and observations "must be recorded immediately". It is not possible to know whether, Mr Parish's death would have been prevented if staff had completed the hourly ACCT checks as required on 21 June. However, staff would have discovered him earlier than they did.

121. Given the troubling range of failings we have identified, given that these are failings we have identified in previous investigations, and given the prison has, on

each occasion, committed to address these failings, we make the following recommendations about the operation of the ACCT procedures at The Mount:

The Prisons Group Director for London and Thames Valley Prisons should assure himself that effective action is taken to implement recommendations from this and previous investigations into deaths at HMP The Mount.

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

- **Holding a multidisciplinary case review within 24 hours of an ACCT plan being opened and when there is evidence of significant change in risk.**
- **Prison and healthcare staff working jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review.**
- **Holding multidisciplinary ACCT reviews, with continuity of case management and involving all staff who can contribute to a prisoner's care.**
- **Case managers completing caremaps at the first ACCT case review, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.**
- **All staff undertaking ACCT observations as directed and actively engaging with prisoners being monitored.**

Staffing levels and safer custody

122. There should have been five officers (including the supervising officer) on duty on Lakes Wing, where Mr Parish lived, on the afternoon that he was found hanged. Only two officers were on duty. Twelve prisoners on the wing were being monitored under ACCT procedures. Of these, staff said that five required monitoring five times an hour and three required monitoring three times an hour. The supervising officer said that generally, the member of staff assigned to a spur also undertook the ACCT checks for that spur. He said that when there was a reduced number of staff, all officers on duty were collectively responsible for ACCT procedures. He said that with staffing below the expected level, staff were unable to fulfil all the duties expected of them, including ACCT checks and answering cell bells promptly, and were unable to deliver the full regime and support to prisoners who required it.

123. It is hard to disagree with this analysis. Managers should have taken steps to ensure effective ACCT monitoring was in place and we make the following recommendation:

The Governor should ensure that when staffing on a unit is reduced, arrangements are in place to ensure that prisoners subject to ACCT procedures are appropriately and formally monitored.

Unlock procedures

124. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual says that staff should physically check prisoners before unlocking them, and that if they do not respond, staff might need to open the cell to check that the prisoner has not escaped, is ill or dead. Prison Service Instruction 75/2011 on Residential Services says that staff should assure themselves of the wellbeing of prisoners during or shortly after unlock.

125. On 21 June, when the officer unlocked Mr Parish's cell at around 1.45pm, he should have checked his welfare and obtained a response from him. We are also concerned that the required hourly observations did not take place. This meant that Mr Parish was not discovered until nearly three hours after Mr Parish was unlocked.

126. The officer who unlocked Mr Parish's cell, told us that he was under pressure to unlock the spur as quickly as possible. While we cannot know whether the outcome for Mr Parish might have been different if he had been found earlier, it is important that prison staff understand and take effective action to comply with the requirement for them to check on prisoners' welfare when they unlock them. Early intervention when a prisoner is found unconscious or in a critical situation might save his life. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the prisoner's wellbeing and that there are no immediate issues that need attention.

Non-compliance with restraining order

127. The court had applied a restraining order prohibiting Mr Parish from contacting his ex-partner. We are concerned that staff facilitated telephone calls to Mr Parish's ex-partner in contravention of the restraining order. Mr Parish's ex-partner told us that this caused her distress. We share her concerns and note that staff failed to check Mr Parish's prison records, which recorded details about public protection and restraining orders, before facilitating the telephone calls. We make the following recommendation:

The Governor should ensure that effective measures are in place to address public protection issues before allowing a prisoner access to all telephone numbers.

Clinical care

128. The clinical reviewer concluded that the general standard of health care Mr Parish received at The Mount was not equivalent to the care he would have received in the community. We agree with her that healthcare staff did not contribute to managing Mr Parish's risk of suicide and self-harm and have addressed this in paragraph 112 of this report.

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