Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Summers, a prisoner at HMP Featherstone, on 23 May 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Thomas Summers was found hanging in his cell at HMP Featherstone on 23 May 2019. He was taken to hospital but died soon after arrival. He was 26 years old. I offer my condolences to Mr Summers' family and friends.

The day before his death, Mr Summers had barricaded himself into a cell saying that he believed he was under threat from other prisoners because of a debt. Given his history of self-harm and impulsive behaviour and his low mood, I consider that he should have been managed under suicide and self-harm procedures (known as ACCT) after the barricade incident.

I am also concerned that when Mr Summers was found hanging, there was a short delay before staff entered his cell and began resuscitation attempts. I cannot say whether this may have affected the outcome for him.

I am satisfied that Mr Summers received good healthcare for his ongoing abdominal pain. However, the investigation found that his mental health care was not of the required standard.

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 **November 2020**

Contents

Summary

Events

1. In April 2015, Mr Thomas Summers was sentenced to four years and eight months imprisonment for robbery. He was released in 2017. In January 2018, he was recalled to custody for committing further offences and sent to HMP Dovegate. He was transferred to HMP Featherstone in May 2018.

2. Mr Summers had a long history of mental ill health, substance misuse and self-harm, and from January 2018 onwards he repeatedly complained of abdominal pain.

3. In May 2018, Mr Summers set fire to his cell and told staff he would be better off dead because of his abdominal pain. He was managed under suicide and self-harm procedures (known as ACCT).

4. He was referred to hospital specialists and had several medical tests to identify the cause of his pain. Although the results did not indicate any serious illness, Mr Summers complained that his symptoms were not improving and that the pain was affecting his mental health.

5. On 22 May 2019, Mr Summers asked two friends to help him barricade a cell because he wanted to be moved to the segregation unit or out of Featherstone because he was in debt. They gave themselves up before staff intervened.

6. On 23 May, Mr Summers was placed on the basic regime and was moved to a different houseblock because of the barricade. He was due to attend a disciplinary hearing the following day. That afternoon, he told a prison chaplain, who knew him well, that he would do 'something' to get a transfer to another prison. The chaplain asked the houseblock staff to keep an eye on him but said that he did not consider it was necessary to start ACCT procedures.

7. At 8.55pm, during a routine roll check (count) of prisoners, an operational support grade (OSG), found Mr Summers' door window panel was covered up and he was not responding to questions. The OSG looked into the cell through the inundation point (an opening where fire hose can be placed if there is a fire) and saw Mr Summers with a ligature around his neck. He radioed an emergency code for assistance. Other staff arrived, cut Mr Summers down, and began CPR.

8. Paramedics arrived and detected signs of life. Mr Summers was taken to hospital by ambulance but died at 10.23pm.

Findings

Clinical Care

9. The clinical reviewer concluded that the healthcare Mr Summers received for his abdominal pain was at least equivalent to that he could have expected in the community.

10. However, the clinical reviewer considered that the mental healthcare Mr Summers received at Featherstone was not up to the required standard. No care plan was

developed to manage his level of risk based on an overall assessment of his anxieties and history of self-harm, and mental health staff did not review Mr Summers after the barricade incident.

11. The clinical reviewer was also concerned that there were no multi-disciplinary team meetings to co-ordinate Mr Summers' physical complaints and his mental health issues.

Identifying risk of suicide and self-harm

12. Mr Summers had several risk factors for suicide and self-harm. We consider that staff should have recognised that his risk factors had increased in the last few days of his life when he told staff he believed he was under threat because of a debt and barricaded in a cell in an attempt to secure a transfer out of Featherstone.

13. We are concerned that staff placed too much emphasis on Mr Summers' presentation and did not give sufficient weight to his risk factors, and that they did not consider opening an ACCT after the barricade incident. We shared the initial report with HM Prison and Probation Service (HMPPS). They said they considered opening an ACCT but deemed it unnecessary as staff had made "fully justified decisions" not to open an ACCT.

14. The chaplain considered whether he should initiate the ACCT process given Mr Summers' low mood but decided against it in favour of staff 'keeping an eye' on him. This meant that the degree of supervision was elastic, open to varied interpretation and there was no log of actions taken to keep him safe.

15. We are also concerned that, although Mr Summers told a prisoner peer mentor that he was thinking of suicide on the afternoon of his death, this was not reported to staff.

Emergency response

16. When the OSG saw Mr Summers hanging, he did not enter the cell immediately but radioed for assistance and waited for other staff to arrive. We are concerned that he did not understand that he should enter a cell in a life-threatening situation, if it is safe to do so. We cannot say whether this affected the outcome for Mr Summers, but a delay of even a few minutes may make a critical difference in a medical emergency.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to consider all relevant information about risk, and start ACCT procedures when indicated.
- The Governor should review the arrangements for the safer custody peer mentor scheme to ensure that information about a prisoner's risk of suicide or self-harm is shared with staff.
- The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies including that night staff enter

cells as quickly as possible in a life-threatening situation, subject to a dynamic risk assessment.

- The Governor should share this report with the prison chaplain who saw Mr Summers on 23 May 2019 and discuss the Ombudsman's findings with him.
- The Governor should share this report with the SO on duty on 23 May 2019 and the OSG who found Mr Summers and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Head of Healthcare should ensure that multi-disciplinary team meetings are held to support prisoners with complex health issues and mental health risk factors to ensure a collaborative approach to assessment and care planning.
- The Head of Healthcare should ensure there is a process in place to refer prisoners with a known history of substance misuse to substance misuse services.
- The Head of Healthcare should ensure that the mental health screening and assessment procedures include a robust and timely process to identify risks and triggers for self-harm and develop care plans to manage those risks.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Featherstone, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner wrote to the investigator.

18. The investigator visited Featherstone on 6 June 2019. She obtained copies of relevant extracts from Mr Summers' prison and medical records.

19. The investigator interviewed 13 staff and 3 prisoners at Featherstone between July and August 2019. She interviewed one member of staff by telephone and one prisoner declined to be interviewed.

20. NHS England commissioned an independent clinical reviewer to review Mr Summers' clinical care at the prison. She joined the investigator for interviews with clinical staff.

21. We informed HM Coroner for South Staffordshire of the investigation. The Coroner gave us the results of the toxicology report. He was satisfied Mr Summers' death was by hanging and did not request a post-mortem examination.

22. We contacted Mr Summers' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Summers' next of kin asked us to consider his long history of mental health issues and attempted suicide. Mr Summers' next of kin asked whether enough was done to treat his son's stomach problems which affected his mood. We have addressed these issues in this report.

23. We shared the initial report with HMPPS. They raised four factual inaccuracies and we have amended the report where appropriate. We shared the report with Mr Summers' next of kin. They have not commented on its contents.

Background Information

HMP Featherstone

24. HMP Featherstone is a medium security, category C prison, holding around 650 sentenced men. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons (HMIP)

25. The most recent inspection of HMP Featherstone was in October 2018. Inspectors reported that staff-prisoner relationships were good, the key worker scheme showed early signs of having a positive impact and there was evidence of good support given to those at risk of suicide and self-harm. A weekly safety interventions meeting provided effective interdepartmental planning by sharing information to support those at risk. A quarter of the prisoners felt unsafe and the rate of violence, although high, was falling. Much of the violence was associated with drugs and debt and more needed to be done to improve safety. Featherstone commented that since the HMIP report was published, they have been working hard to address violence and anti-social behaviour and have undertaken some in-depth analysis to identify causes of violence and likely hotspots.

Independent Monitoring Board

26. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to October 2019, the IMB reported that support for vulnerable prisoners was well-organised. Prisoners had good access to integrated mental health and psychosocial substance misuse services. Most healthcare complaints were about medication and external hospital appointments. The Board expressed its concern about 25% of prisoners as identified in the HMIP report feeling unsafe particularly in houseblocks 1- 4. It noted that the Care and Separation (segregation) unit was often seen by prisoners as a way to secure a move to another establishment.

Previous deaths at HMP Featherstone

27. Mr Summers was the third prisoner since 2016 to take his own life at Featherstone. There are similarities with the previous cases in that one of the prisoners had been recalled to custody and had been in debt which had followed him from previous prisons. The other prisoner had been involved in a barricading incident before his death.

Assessment, Care in Custody and Teamwork (ACCT)

28. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner.

29. 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 made at irregular intervals to prevent the prisoner anticipating when they will occur.

Part of the ACCT process involves assessing immediate needs and drawing up a caremap (a plan of care, support and intervention) to identify the prisoner's most urgent issues and how they will be met. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

30. Mr Thomas Summers had a history of depression and anxiety and had been detained in a psychiatric unit after attempting suicide in the community aged 18. He was diagnosed with EUPD (Emotionally Unstable Personality Disorder). He had misused alcohol and many types of illegal drugs since his teenage years. He had been under the care of the mental health services at different prisons and had made several attempts at deliberate self-harm, including making cuts to his arms and an overdose of heroin in 2013.

31. On 16 April 2015, Mr Summers was sentenced to four years and eight months for robbery. From 2016, Mr Summers regularly complained of a sore throat and coughing up blood. This was thoroughly investigated by prison GPs and hospital specialists. He was placed on a waiting list to have his tonsils removed but the operation did not take place and Mr Summers did not complain about his throat again after 2017.

32. In June 2016 at HMP Swaleside, he told a mental health nurse that he was feeling paranoid and depressed because he owed another prisoner £700. He set fire to his cell and was moved to another establishment.

33. He was released in 2017 and recalled to custody on 22 January 2018 after committing further offences of theft. He was sent to HMP Dovegate.

HMP Dovegate: January – May 2018

34. When he arrived at Dovegate, Mr Summers said he had injected a large amount of heroin into his stomach a week earlier in an attempt to kill himself and that he was worried about damage to his abdominal organs. Suicide and self-harm prevention procedures (known as ACCT) were opened but were closed after a few days as he said he no longer had any thoughts of self-harm once his detox medication had been sorted out.

35. From March 2018 onwards, Mr Summers began to complain of a wide range of abdominal symptoms which were investigated by prison GPs who referred him to hospital specialists. The results of tests and scans showed nothing abnormal and he was diagnosed with flatulent dyspepsia (excessive gas and bloating).

36. In April, ACCT procedures were re-started after Mr Summers cut his neck several times with a razor blade. He told the ACCT assessor that he had been struggling with stomach pain for three years, medication had not worked and he was feeling low because he could not see any hope. He was moved to the healthcare centre for observation. The ACCT was closed after six days when Mr Summers said he had not had thoughts of self-harm since he moved to the healthcare centre. At the post-closure ACCT interview at the end of April, Mr Summers said his stomach problem was ongoing, but he did not have any thoughts of suicide or self-harm. The ACCT remained closed.

HMP Featherstone: May 2018 onwards

37. In May, Mr Summers moved to HMP Featherstone. He was assessed on reception by a nurse who noted that he was taking medication for gastro-intestinal

issues and referred him to a prison GP to re-prescribe his medications. Mr Summers told the nurse that he had taken an overdose and attempted suicide in the past 12 months. He declined the healthy lifestyle programme. She referred him to the mental health team as he appeared distracted and there was visible evidence of self-harm scars on his neck.

38. Two days after his arrival, Mr Summers set fire to his bedding and a towel using the wires from his kettle. ACCT procedures were begun. At a multi-disciplinary ACCT review, Mr Summers said that he had started the fire because his health issues had not been addressed. He said Dovegate had transferred him to Featherstone on the day he had an hospital appointment for a hiatus hernia which was giving him a lot of pain. He was referred to the GP and the mental health team.

39. At the end of May, a nurse reviewed Mr Summers' mental health referral. She noted that he had a history of low mood, anxiety and poor coping skills. Mr Summers declined to take part in group work and said that his physical ill-health was at the root of his problems. He was discharged from the mental health team caseload.

40. The ACCT was closed at the beginning of June when Mr Summers said he had no further thoughts of suicide or self-harm.

41. Over June and July, Mr Summers continued to complain to healthcare staff of abdominal pain and a variety of digestive symptoms. Prison staff gave him light duties or allowed him to rest in his cell. Mr Summers' key worker (a dedicated officer who offers support and regular documented contact to encourage good behaviour and trust) said Mr Summers frequently spoke about his physical ill-health and stomach issues. Mr Summers often visited the Chaplaincy department and chatted with the Chaplains. He attended church services and prayer groups regularly.

42. Prison GPs referred Mr Summers for ultrasound examinations, a coeliac disease screen and an endoscopy (examination of the stomach and small intestine with a small camera). The results of the tests were normal. A prison GP told the investigator that Mr Summers remained anxious about his symptoms and that although he spent a generous amount of time trying to reassure him that his symptoms had been well-explored, Mr Summers was unconvinced.

2019

43. On 18 January, Mr Summers had an MRI scan, the result of which was normal. After prison GPs had considered the results of his various scans and tests, they concluded that his symptoms were the result of his bowel function rather than any physical abnormality. He was prescribed amitriptyline, a medication that eases abdominal spasms associated with Irritable Bowel Syndrome.

44. Mr Summers continued to complain of feeling unwell. On 19 March, he requested an appointment with the mental health team as he said he was feeling anxious and low in mood because of his stomach pain. Two nurses reviewed his notes, wrote in his record that he had EUPD and arranged a triage appointment for 22 March. He had further tests including faeces culture on 20 March, the results of which

were normal. He told a nurse that he would cut himself if he was not taken to hospital. On 26 March, a nurse explained to him that there was no sign of disease or any serious condition. Mr Summers turned up late for his mental health appointment on 27 March and was given another for 1 April. A nurse offered him a place on the Anxiety and Depression Group. He declined and was discharged from the mental health team workload.

45. On 3 April, Mr Summers telephoned his next of kin using another prisoner's account and asked her to pay £15-£20 into a different prisoner's account. He said that a prisoner on the houseblock had a 'shop' selling canteen goods at double the price. On 4 April, he telephoned his mother three times to make sure she had deposited the money. On 22 April, Mr Summers telephoned his next of kin again and asked her to send some money. She replied that she was not sure she could. He did not telephone her again.

46. On 11 April, Mr Summers had blood tests for allergies and lactose intolerance. These showed that he had an allergy to nuts and mild gluten and lactose intolerance. A prison GP discussed his blood test results with him on 3 May and Mr Summers agreed that he should try to eliminate nuts, dairy and wheat from his diet. The prison GP wrote in his clinical record that he had a long supportive discussion with Mr Summers and that his mood seemed positive.

47. On 17 May, Mr Summers' keyworker met with him. Mr Summers said he believed there was a 'hit' out on him for a debt incurred in a previous prison and that he needed to move off Houseblock 3 or to another prison. Mr Summers' keyworker told him he could request a move if he stated his reasons. Mr Summers ended the conversation and said he had nothing more to say.

Barricade on 22 May

48. On the afternoon of 22 May, Mr Summers went to the Chaplaincy department to see a prison chaplain, but it was closed for cleaning. At 7.30pm, a note was pushed under the door of a cell to an officer who was in the corridor outside, saying that three prisoners were barricaded in the cell and one was being held hostage. The officer tried to open the cell door but was unable to do so. He immediately informed a supervising officer (SO). They identified the three prisoners in the cell as Prisoners A and B and Mr Summers.

49. Trained hostage negotiators contacted the prisoners and established that it was not a genuine hostage situation, but that the prisoners had colluded to say that it was because Mr Summers wanted to leave Featherstone as soon as possible. At 9.50pm, staff were about to force their way into the cell when the prisoners surrendered.

50. Prison Service policy requires that prisoners are checked by a member of healthcare staff after a hostage incident. As there is no healthcare cover on-site at Featherstone overnight, HMYOI Brinsford which is opposite Featherstone, was asked to provide a nurse. A nurse who was on duty in Brinsford, attended the scene of the barricade. She did not update the prisoners' clinical records as she was unable to access Featherstone's computerised case notes system. She sent an email to Featherstone's Head of Healthcare, which said, "There were no

apparent injuries and all observations were normal for two of the men. I didn't see the 3rd as he was seen by [a healthcare assistant] but he reported no concerns".

51. Prisoner B and Mr Summers were returned to their own cells and Prisoner A remained in the cell where the barricade had taken place.

52. The investigator asked a SO whether he was aware at the time that prison staff (as recorded in the Silver Commander Incident Management Decision Record) thought the cell smelled of smoke and possibly of psychoactive substances (PS). He said that he was but the prisoners did not behave as if they were under the influence of illicit substances though he was aware that the effect of PS could wear off quickly. An assessment in Mr Summers' Mercury security record described all three prisoners as appearing "under the influence" when they left the cell.

Events of 23 May 2019

IEP review

53. At 12.15pm the following day, Mr Summers was reduced from the standard regime to the basic regime under the Incentives and Earned Privileges (IEP) scheme because of his involvement in the barricade. This meant that he would be on a restricted regime and lose access to some facilities, including a television in his cell. Mr Summers told the SO who headed the IEP board that he was in debt to another (unidentified) prisoner and wanted to move. The SO arranged for Mr Summers to move to Houseblock 4 that afternoon and referred him to the violence reduction team.

Houseblock 4

54. A custodial manager (CM), a safer custody manager with responsibility for violence reduction, escorted Mr Summers to Houseblock 4 at around 4.00pm and placed him in cell 14 (which was awaiting refurbishment but was the only cell available). He explained to him that a prisoner peer violence reduction representative would visit him that day to talk about his situation. Mr Summers said that being on Houseblock 4 would make matters worse as other prisoners would soon notice him and be at his door. The CM said that Mr Summers would be safe because he would be locked in his cell until he went to the segregation unit the next morning for a disciplinary hearing following the barricade. The CM said he would be on duty in the segregation unit in the morning and they would talk about next steps. The CM told the investigator he thought Mr Summers seemed reassured that he would not be unlocked until the next day.

55. The chaplain heard that Mr Summers had barricaded his cell the night before and visited him on Houseblock 4 shortly after he had moved there. Mr Summers told him he had barricaded to get a move to the segregation unit or out of the prison because he was in debt. Mr Summers said several times that he would have to do "something", but when the chaplain asked him what he was planning, he replied that he would not do anything to himself and that the person he was in debt to was not on the houseblock. He said they would talk again the next day and sort it out. Mr Summers thanked him for visiting and agreed that they would meet as planned.

56. The chaplain went to the staff office on the houseblock and asked the officers to keep an eye on Mr Summers. An officer wrote in the wing observation book that

the chaplain was concerned about Mr Summers as his mood was quite low. He told the investigator he asked the chaplain whether he would be opening an ACCT and the chaplain replied he did not think Mr Summers justified one.

57. The chaplain also went to the SO's office and repeated his concerns about Mr Summers. The SO asked him whether Mr Summers needed to be on an ACCT. The chaplain replied "no" as he did not think Mr Summers wanted to harm himself. The investigator asked the chaplain whether he had considered opening an ACCT. He replied that he had mulled it over initially but when Mr Summers sat on his bed and spoke he seemed more relaxed and he thought he would probably damage his cell rather than himself.

58. An officer checked on Mr Summers approximately 20 minutes after the chaplain left the houseblock. He told the investigator that Mr Summers' observation panel was covered and he did not answer when the officer called him. The officer went to the staff office to retrieve the key to the inundation point (an opening where fire hose can be placed if there is a fire). He opened the point to Mr Summers cell and asked Mr Summers what was the matter. Mr Summers said he would smash up his cell unless he was moved. The SO told him he would not be going to the segregation unit that day. She told the investigator that Mr Summers kicked the seat off his toilet and said calmly that he would do what he had to do.

59. At 5.00pm, an officer unlocked Mr Summers as another officer from the segregation unit had arrived to give Mr Summers the documentation for his disciplinary hearing the next day.

60. At 6.00pm, a prisoner peer mentor from the violence reduction team, visited Mr Summers because of the barricade incident. Mr Summers told him that he had "debt issues" and had barricaded as he was worried about how he would pay off £700 he owed. He would not disclose who the money was owed to. He told the investigator Mr Summers said he was not coping with the stress and he would "string up or cut up". He asked him not to say that, even in jest. Mr Summers said he did not feel safe on Houseblock 4 and wanted to go to the segregation unit. He completed a violence reduction contact sheet said he would pass the information on to the safer custody team. The contact sheet did not mention Mr Summers' comment about self-harm.

61. An officer did a roll check of prisoners in Houseblock 4 at about 7.30pm. She put some mail under Mr Summer's cell door that an officer from Houseblock 3 had brought over. He thanked her and asked her whether he would be able to get some property he had left on the house block. She explained that it was too late in the evening as all the wings were locked up but she would sort it out the next day. Mr Summers was last seen alive at 8.10pm by the officer when she gave him some shampoo sachets he had asked for.

62. An operational support grade (OSG) arrived for night duty on Houseblock 4 at about 8.30pm. An officer gave him a handover and alerted him to the entry in the observation book about Mr Summers.

63. At 8.56pm, the OSG began a routine roll check (count) of the prisoners. When he went to check Mr Summers, his door window panel was covered up and he did not respond to questions. The OSG counted the remaining spur and then returned

and unlocked the inundation point and looked into Mr Summers' cell. He saw Mr Summers apparently sitting on the floor with a ligature around his neck. He radioed a medical emergency code blue at 8.59pm and an ambulance was called.

64. The OSG did not enter the cell but waited until other staff arrived. A Custodial Manager (CM) was the most senior officer on night duty. When he heard the code blue, he ran to Houseblock 4, together with another CM and an officer. A CM told the investigator that as they reached the spur, he could see the OSG with his key in the Mr Summers' cell door but he had not unlocked the door. A CM told him to unlock the door and they all went into the cell together.

65. Mr Summers was sitting on the floor in the far left corner of his cell with a ligature around his neck which was attached to a wall cupboard. His legs were stretched out in front of him but his heels were not actually touching the floor. A CM cut the ligature with an anti-ligature tool and lowered Mr Summers to the floor on his back. A CM said he was not responsive, there were no signs that he was breathing and his skin looked grey. The two CMs began CPR while an officer left the cell briefly to find a defibrillator.

66. A first ambulance arrived at 9.10pm and paramedics took over resuscitation attempts. Another ambulance and a rapid response vehicle arrived at 9.23pm. Signs of life were detected and once he was stabilised, Mr Summers was taken to hospital at 9.56pm in an ambulance, accompanied by escorting staff. He did not regain consciousness and was pronounced dead at 10.23pm.

Contact with Mr Summers' family

67. Mr Summers had not provided any next of kin details when he entered prison. Staff could not access his PIN phone records and asked Staffordshire police for assistance. They contacted Mr Summers' mother, who broke the news to his father.

68. On 24 May, a senior manager telephoned Mr Summers' father and expressed her condolences. A prison family liaison officer contacted Mr Summers' mother. The Governor wrote to his next of kin and offered to contribute to the cost of Mr Summers' funeral, in line with national policy.

Support for prisoners and staff

69. After Mr Summer's death, a senior manager debriefed the staff involved in the emergency to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

70. The prison posted notices informing other prisoners of Mr Summers' 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 Summers' death. A memorial service was held and was well attended by prisoners and staff.

Post-mortem report

71. The coroner was satisfied that Mr Summers' death was caused by hanging and did not request a post-mortem examination. Toxicology tests found mirtazapine (an anti-depressant which he had been prescribed) present in Mr Summer's blood,

and also a synthetic cannabinoid (PS), suggesting Mr Summers had used it before his death.

Findings

Identifying risk of suicide and self-harm

72. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Featherstone should have recognised that Mr Summers was at risk and started ACCT procedures after the barricade incident on 22 May.

73. Mr Summers had several risk factors for suicide. He had a history of self-harm and attempted suicide and suffered from depression and anxiety. He was low in mood because of worries about his health. His history of setting fire to his cell and the recent barricade showed that he was liable to act on impulse. He had recently disclosed debts and believed he was under threat as a result and wanted to leave Featherstone. His privileges had been reduced to the lowest level on the morning of his death and he had been relocated to an unrefurbished cell on a houseblock he did not want to be on. He was awaiting a disciplinary hearing for the barricade.

74. We think that in these circumstances, the barricade incident should have been seen as a significant event indicating that Mr Summers was under stress and that staff should have given it more weight. After considering the initial report, Featherstone responded that it considered opening an ACCT after the barricade incident but deemed it unnecessary as Mr Summers low mood was because his plan to move prisons had not worked and he did not make any reference to self-harm or suicide.

75. After moving to Houseblock 4, Mr Summers told the chaplain that he would 'do something'. The chaplain was sufficiently concerned about him to speak to staff in the office and to a SO to ask them to 'keep an eye' on him. We consider that in these circumstances the chaplain should have opened an ACCT. We have said many times before that staff should consider a prisoner's risk factors when assessing their risk of suicide and self-harm and should not simply rely on what the prisoner says or how the prisoner appears to them.

76. We consider that, in the light of the chaplain's request, a SO should have considered Mr Summers' risk factors and spoken to him herself to reach her own conclusion, rather than relying on the chaplain's view that an ACCT was not necessary.

77. We are also very concerned that the prisoner peer mentor, did not tell staff that Mr Summers had talked about hanging or cutting himself. We consider that peer mentors need to be made aware of the need to share information about potential suicide or self-harm.

78. Without an ACCT, the degree of supervision was elastic, open to varied interpretation and there was no log of actions to be taken to keep Mr Summers safe. An ACCT would not necessarily have prevented Mr Summers taking his life but should have meant that the OSG would have acted with greater urgency when he found Mr Summers' door panel blocked and could get no response from him.

As it was, he continued his roll check and fetched the key to the inundation point before returning to Mr Summers' cell.

79. We recommend:

The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and the need to consider all relevant information about risk, and start ACCT procedures when indicated.

The Governor should share this report with the prison chaplain who saw Mr Summers on 23 May 2019 and discuss the Ombudsman's findings with him.

The Governor should share this report with the SO on duty on 23 May 2019 and the OSG who found Mr Summers and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Governor should review the arrangements for the safer custody peer mentor scheme to ensure that information about a prisoner's risk of suicide or self-harm is shared with staff.

Emergency response

80. PSI 24/2011, which covers management and security at night, says that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe should be used to make a rapid dynamic assessment. At night, operational support grades and officers carry a key in a sealed pouch to use to open a cell in an emergency and should be prepared to use it if necessary.

81. Featherstone issued a Notice to Staff in February 2019 clarifying the circumstances when a member of staff should enter a cell alone. This said:

> "Where there appears to be imminent danger to life and subject to a dynamic risk assessment, a member of staff can enter alone. You must do so only after making an emergency call for assistance using the emergency response code … this call for help must be acknowledged before entering a cell alone."

82. When the OSG saw Mr Summers hanging, he correctly called an emergency code but there was then a short delay while he waited for other staff to arrive. We are concerned that he said he would never consider opening a cell and entering on his own, even in an apparent emergency. We cannot know whether the outcome might have been different if the ligature had been removed more quickly, but we do know that a delay of even a few minutes may make a critical difference in a medical emergency. We recommend:

The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies including that night staff

enter cells as quickly as possible in a life-threatening situation, subject to a dynamic risk assessment.

Clinical care

83. The clinical reviewer concluded the healthcare Mr Summers received for his physical health concerns was of a reasonable standard and at least equivalent to that he would have received in the community. He was frequently seen by the prison GPs when he complained of abdominal pain and they had long and supportive discussions with him about his gastro-intestinal issues. They made a number of referrals to hospital specialists for further investigations based on his presenting symptoms and test results.

84. However, the clinical reviewer considered that the mental healthcare Mr Summers received at Featherstone was not up to the standard that should have been provided. He had been referred and was seen by several members of the mental health services, but no care plan was developed to manage his level of risk based on an overall assessment of his anxieties and history of self-harm. She was also concerned that no multi-disciplinary team meetings were held to co-ordinate Mr Summers' physical complaints and his associated mental health issues and concerns.

85. The clinical reviewer also considered that mental health staff should have reviewed Mr Summers on 23 May after the barricade incident the previous evening.

86. Although staff were not aware that Mr Summers was using illicit drugs at Featherstone, the clinical reviewer considered that, given his long history of substance misuse, he should have been referred to the substance misuse services when he arrived at Featherstone.

87. The clinical reviewer also considered that healthcare record keeping needed improvement. When the nurse from Brinsford saw Mr Summers after the barricade, she was not able to record her interaction with him as she did not have access to his clinical notes. Care UK had out of hours arrangements in place and should have used them.

88. We recommend:

The Head of Healthcare should ensure that the mental health screening and assessment procedures include a robust and timely process to identify risks and triggers for self-harm and develop care plans to manage those risks.

The Head of Healthcare should ensure that multi-disciplinary team meetings are held to support prisoners with complex health issues and mental health risk factors to ensure a collaborative approach to assessment and care planning.

The Head of Healthcare should ensure there is a process in place to refer prisoners with a known history of substance misuse to substance misuse services.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141