Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Mellors a prisoner at HMP Manchester on 25 February 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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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 Simon Mellors was found hanged in his cell on 25 February 2018, at HMP Manchester. He was 56 years old. I offer my condolences to Mr Mellors' family and friends.

In 1999 Mr Mellors was convicted of murdering his former partner. He was released from prison in 2014. On 29 January 2018 he was charged with the murder of another ex-partner and the attempted murder and grievous bodily harm of a police community support officer, and was remanded into custody at HMP Nottingham. He was transferred to Manchester on 7 February.

Mr Mellors was not assessed by the mental health team at Nottingham or Manchester and we are concerned that in managing Mr Mellors' risk of suicide and self-harm, staff relied too heavily on his presentation rather than his known risk factors. Staff at both Nottingham and Manchester were confused about whether Mr Mellors was being monitored under suicide and self-harm prevention procedures when he was transferred.

There have been eight self-inflicted deaths at Nottingham between February 2017 and February 2018, and Mr Mellors' death is the second of three self-inflicted deaths at Manchester in 2018.

I am very concerned that this report repeats recommendations made following previous investigations into self-inflicted deaths at Nottingham and Manchester, including the need to improve suicide and self-harm prevention procedures, the need for healthcare staff to understand when mental health referrals are appropriate, and the need for staff to be aware of the appropriate code to communicate the nature of a medical emergency effectively. The Executive Director for the Long-Term and High Security Estate and the Prison Group Director for the East Midlands should assure themselves that meaningful action is now taken to address our recommendations.

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 **November 2018**

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Summary

Events

1. On 17 April 2014, Mr Simon Mellors was released from HMP Sudbury on licence after serving a 14-year life sentence for murder. He had a history of suicide attempts, depression and a diagnosis of anti-social personality disorder. On 29 January 2018, Mr Mellors was charged with murder, attempted murder and grievous bodily harm. After allegedly committing the offences, he drove his car into a tree and fractured his spine. On 1 February, Mr Mellors was sent to HMP Nottingham.

2. Staff in reception started suicide and self-harm prevention procedures (known as ACCT). A nurse in reception assessed Mr Mellors and referred him to the mental health team. The nurse and a prison manager held Mr Mellors' first ACCT case review and noted that he had no thoughts of suicide or self-harm. They assessed his risk as low. Mr Mellors was located in the segregation unit as a potential category A prisoner.

3. On 2 February, Mr Mellors had his second ACCT case review and staff noted that his main concern was his physical health. They assessed Mr Mellors' risk as low. Three days later at his next case review, staff decided to close Mr Mellors' ACCT document. A prison manager noted in the ACCT document that the ACCT had been closed but did not record this on Mr Mellors' prison record.

4. On 6 February, a mental health nurse reviewed Mr Mellors but did not carry out a full mental health assessment because Mr Mellors did not have a history of mental health problems and told her he did not have any thoughts of suicide or self-harm.

5. On 7 February, Mr Mellors was transferred to HMP Manchester. A manager at Nottingham was confused about whether the ACCT was open or closed so held an ACCT case review. An officer from Manchester said that when he arrived at Nottingham to collect Mr Mellors, a prison manager told him that the ACCT had been closed and staff were about to hold the post-closure review. The manager who held the ACCT case review remembered speaking to staff from Manchester but could not remember what he told them about the ACCT.

6. When Mr Mellors arrived at Manchester, a nurse assessed him as part of a reception screening. The nurse did not have his Person Escort Record or his ACCT document and did not review his prison record or medical record before conducting the assessment. The nurse did not refer Mr Mellors to the mental health team.

7. Mr Mellors was located in the healthcare unit in an enhanced care suite (a cell with a hoist to help move prisoners with impaired mobility) to accommodate his wheelchair. A nurse noted in Mr Mellors' medical records that his ACCT remained open. Staff could not find his ACCT document so they started a new ACCT document. The next day, the supervising officer who collected Mr Mellors from Manchester told staff that Mr Mellors' ACCT had been closed. He could not find the post-closure review document so an officer conducted a post-closure review.

8. Mr Mellors spoke to a nurse about the accident and his offence on three occasions, saying that he kept seeing his victim's face, that it was haunting him and he wanted it to stop. He also referred to his previous offence, was crying on one occasion and said he felt numb and "wished it had never happened". The nurse suggested that Mr Mellors speak to the mental health team or a psychiatrist but did not make a referral because he said he did not want to speak to anyone. Mr Mellors had a number of risk factors for suicide but the nurse did not consider starting ACCT procedures.

9. On 22 February, Mr Mellors had a panic attack after the nurse spoke to him about removing his wheelchair as part of attempts to improve his mobility. On 23 February, he told the same nurse that he was neglecting his personal hygiene.

10. At around 7.00am on 25 February, an officer said she checked Mr Mellors and saw him getting out of bed. At 8.30am, another officer went to Mr Mellors' cell and found him hanging from the hoist near the toilet area. He called for help and supported Mr Mellors' weight and borrowed another officer's knife to cut the ligature. A nurse arrived and said that staff should not resuscitate Mr Mellors because he had died. The control room called an ambulance at 8.52am, paramedics arrived and confirmed that Mr Mellors had died at 9.02am.

Findings

11. The investigation found that staff at Nottingham and Manchester relied on Mr Mellors' presentation rather than his known risk factors (his offending history, previous suicide attempts, recall to prison and the length of his time in custody), when assessing his level of risk of suicide and self-harm.

12. Staff at Nottingham did not conduct ACCT procedures in line with national guidance. Caremap actions were not specific, meaningful and time bound and we consider that observations that were set did not reflect Mr Mellors' level of risk.

13. We consider that Mr Mellors' ACCT document should not have been closed before he transferred from Nottingham. Staff there closed the ACCT despite failing to consider or address Mr Mellors' risk factors at a time when he was about to transfer to a higher security establishment.

14. Staff at Nottingham and Manchester were confused about whether Mr Mellors' ACCT was open or closed when he transferred. Staff at Nottingham did not note on Mr Mellors' ACCT document that the ACCT had been closed, did not review the ACCT document before holding a case review prior to transfer and failed to effectively communicate information about Mr Mellors' risk and his ACCT document to staff at Manchester.

15. Reception staff at Manchester did not consider all relevant information when assessing Mr Mellors' level of risk including his medical records, prison record, ACCT document or Person Escort Record.

16. Staff at Manchester were confused and disorganised in the face of Mr Mellors' risk of suicide and self-harm and did not make sufficient efforts to understand how this had been managed before he was transferred there. They were distracted from addressing his risk of suicide and self-harm by his physical

condition. They did not consider re-opening Mr Mellors' ACCT document despite his clear risk factors and his disclosure that he was experiencing distress related to his alleged and previous offences.

17. Mr Mellors did not have a mental health assessment in prison. He was referred for a mental health assessment at Nottingham but the mental health nurse said she did not carry out a mental health assessment because he did not have a history of mental health problems and said he was not at risk of suicide or self-harm. Staff at Manchester did not refer Mr Mellors to the mental health team even though he had panic attacks and was tearful when speaking about being charged with the murder of his partner.

18. We are concerned that healthcare staff at Manchester did not know the emergency medical codes and that a debrief was not held for staff after Mr Mellors' death.

Recommendations

- The Governor of Nottingham should ensure that staff assess and manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that:
  - The assessment of risk takes account of all the prisoner's circumstances and risk factors and not just their personal presentation.
  - ACCTs are not closed where it is known a prisoner will be transferring.

- The Governor of Nottingham should review the operation and management of the ACCT process to ensure that information is accurately recorded and that staff share information to provide collaborative care.

- The Governor of Nottingham should ensure that:
  - ACCT caremaps have specific, meaningful and time bound actions, aimed at reducing prisoners' risks to themselves, progress should be considered at each review and the caremaps updated if additional needs are identified.
  - Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations which reflects that risk.

- The Head of Healthcare at Nottingham should ensure mental health assessments take into account all relevant information, including any previous mental health diagnosis, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines.

- The Governor of Manchester and the Head of Healthcare should ensure that staff are aware of, consider and record all known risk factors and triggers for suicide and self-harm and open an ACCT where the prisoner has significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.

- The Governor of Manchester should ensure that ACCT post-closure reviews are conducted in line with Prison Service instructions and should be held to check the prisoner's progress and to decide whether further monitoring is needed.

- The Governor and Head of Healthcare at Manchester should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm.

- The Head of Healthcare at Manchester should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate, and make a referral when indicated.

- The Head of Healthcare at Manchester should ensure that all staff understand and are confident in using emergency call signs.

- The Governor and Head of Healthcare at Manchester should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.

- The Executive Director for the Long-Term and High Security Estate and the Prison Group Director for the East Midlands should assure themselves that meaningful action is taken to address our recommendations.

The Investigation Process

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

20. The investigator visited HMP Manchester on 6 March 2018. She obtained copies of relevant extracts from Mr Mellors' prison and medical records.

21. NHS England commissioned a clinical reviewer to review Mr Mellors' clinical care at the prison.

22. The investigator and clinical reviewer interviewed five members of staff at HMP Nottingham on 23 April and eight members of staff at HMP Manchester on 24 April. The investigator interviewed a further two members of staff at HMP Nottingham by phone on 8 May, and one member of staff on 16 July.

23. We informed HM Coroner for Manchester of the investigation. We had not received a copy of the post-mortem examination at the time of writing this report. We have sent the coroner a copy of this report.

24. One of the Ombudsman's family liaison officers contacted Mr Mellors' brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any issues for consideration.

25. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies which have been amended accordingly. The action plan is annexed to this report.

26. Mr Mellors' family were provided with a copy of the initial report. They raised one factual inaccuracy which has been amended accordingly.

Background Information

HMP Manchester

27. HMP Manchester operates as both a high security prison and a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester Mental Health and Social Care Trust provides 24-hour nursing care and the healthcare centre includes an inpatient unit.

HMP Nottingham

28. HMP Nottingham is a local prison holding a maximum of 1,060 men and young adult prisoners on remand, convicted or sentenced. The prison serves the courts of Nottinghamshire and Derbyshire. Nottinghamshire Healthcare NHS Foundation Trust provides health services, including mental health services. The prison has 24-hour primary healthcare cover. Mental health care is available Monday to Friday, 8.00am to 5.00pm.

HM Inspectorate of Prisons

29. The last inspection of HMP Manchester was in November 2014. Inspectors reported that violence was increasing but still less prevalent than at similar prisons. They found that self-harm levels were lower than at similar prisons and there was good management of risk. Inspectors also reported that newly arrived prisoners were screened for mental health issues and appropriate referrals were made. Prisoners surveyed told inspectors that it was easy to obtain illicit drugs in Manchester.

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

31. Key findings from the inspection of Nottingham included:

    - Over two thirds of prisoners told inspectors they had felt unsafe at some point during their stay at the prison.
    - Over a third of prisoners said they felt unsafe at the time of the inspection.
    - Levels of self-harm remained very high and had increased since the last inspection in February 2016. In a survey, 30% of prisoners said that they had been subject to case management interventions (ACCT) at some point during their stay, but too many prisoners felt the support and engagement offered was either insufficient or inconsistent.
    - Levels of violence overall were higher than in comparable prisons and had not reduced since the last inspection in February 2016.

- There were repeated failures to achieve or embed improvements following previous recommendations made by the Prisons and Probation Ombudsman (PPO).

Independent Monitoring Boards

32. 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.

33. In its latest annual report for Manchester for the year to February 2017, the IMB reported that the number of prisoner on prisoner assaults had fallen by 16 per cent from the previous year. The IMB were concerned that the redeployment of staff due to staff shortages had negatively impacted the safer custody function at Manchester.

34. In its annual report for Nottingham, published in July 2018, the IMB were very concerned about the very high levels of self-harm. The IMB noted that there were no mental health staff available at night or at weekends to support officers dealing with prisoners with mental health problems.

Previous deaths at HMP Manchester and HMP Nottingham

35. There have been 17 deaths at Manchester since 2016 and Mr Mellors' death is the second of three self-inflicted deaths in 2018. This report raises similar concerns to those that have been found in previous investigations, including recording, sharing and considering all relevant information about risk and starting ACCT procedures when indicated; healthcare staff being aware of the circumstances where mental health referrals are appropriate; and staff being aware of the appropriate emergency medical code to communicate the nature of an emergency effectively.

36. There have been 12 deaths at HMP Nottingham since January 2016. 11 of the previous deaths were self-inflicted. Between February 2017 and February 2018, there were eight self-inflicted deaths at HMP Nottingham. Similar issues were raised in previous investigations, including conducting ACCT reviews and post-closure reviews in line with national instructions and identifying and considering all known risk factors. Concerns about poor mental health service provision at Nottingham were also raised in previous investigations.

Assessment, Care in Custody and Teamwork

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

prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

38. On 23 December 1999, Mr Simon Mellors was sentenced to life imprisonment for the murder of his partner. Mr Mellors attempted suicide before arriving in prison and was monitored under the ACCT process during his first few months in custody. He was also treated for depression. During his sentence, Mr Mellors was diagnosed with anti-social personality disorder. On 17 April 2014, he was released from HMP Sudbury on life licence.

39. On 29 January 2018, Mr Mellors was charged with murder of his ex-partner and attempted murder and grievous bodily harm of a police community support officer and was recalled to prison. After Mr Mellors allegedly committed these offences, he drove his car into a tree and broke his back. He was taken to Nottingham City Hospital for treatment and was taken back into police custody the next day.

HMP Nottingham

40. On 1 February 2018, Mr Mellors was sent to HMP Nottingham. His Person Escort Record (PER) noted that he had depression, had driven his car into a tree and had been charged with murder. (A PER accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors.) An officer started suicide and self-harm procedures known as ACCT and noted that Mr Mellors had driven his car into a tree in an attempt to kill himself.

41. At 5.00pm, an officer assessed Mr Mellors under the ACCT process. Mr Mellors said that he had been involved in a car accident and had had no intention to hit the tree but lost control due to 'red mist'. Mr Mellors told the officer that he had not self-harmed in the past 18 years. He said that his injury was very painful and he wanted to see healthcare staff to sort out his medication. The officer noted that Mr Mellors was very polite and engaging throughout the assessment and was aware of the ACCT process and the support that was available to him.

42. A nurse assessed Mr Mellors in reception. She noted that there had been a 'recent life changing event' for Mr Mellors. She said that Mr Mellors was very calm and answered her questions but was not overly chatty. She noted that he had not attempted suicide or self-harmed in the past 12 months and that he had no thoughts of suicide or self-harm. She referred Mr Mellors to the mental health team and noted 'ongoing mental health issues'. She told the investigator that she could not remember her reasons for referring Mr Mellors to the mental health team or the details of her conversation with Mr Mellors.

43. During the reception screening, a prison manager held the first ACCT case review. Mr Mellors told him that he would not self-harm. The manager noted three actions on the ACCT caremap: lost glasses, shock and physical injuries. He assessed Mr Mellors' risk of self-harm as low and noted that he should be observed once an hour. The reception nurse said that although she was present during the review she could not remember its content.

44. The manager noted that Mr Mellors would be located in the segregation unit because he was a possible category A prisoner, given his alleged index offence. Another prison manager told the investigator that it is standard protocol to locate

potential category A prisoners in the segregation unit because it is the most secure part of the prison. Mr Mellors told the manager that he would prefer to be located in the segregation unit.

45. On 2 February, Mr Mellors attended an ACCT case review with a prison manager, two nurses and an officer from the segregation unit. One of the nurses said that Mr Mellors' main concerns were his physical health and that he wanted pain relief medication. Staff added 'movement issues' as an action in the caremap. Mr Mellors said that he had no thoughts of self-harm and staff assessed his risk as low. The nurse told the investigator that Mr Mellors' risk was assessed as low because there was a lot more intensive observation of a prisoner in the segregation unit. The nurse noted that Mr Mellors would be observed once an hour and continue to be managed under the ACCT process until he had been assessed by the mental health team.

46. On 5 February, a prison manager, a nurse, a member of the IMB and a chaplain held an ACCT case review. Mr Mellors said that he had hit the tree after driving at his victim and did not even see it. He told staff that he could see no reason for the ACCT to remain open. The nurse told the investigator that Mr Mellors appeared quite calm and stable during the review and said he had no thoughts of suicide or self-harm. The nurse noted that Mr Mellors asked for his glasses, that prison staff would look for them, and that an optician appointment had been booked. They decided to close the ACCT document and the manager noted that the post-closure interview should be held by 12 February. The manager did not note on Mr Mellors' prison record that the ACCT had been closed.

47. On 6 February, a mental health nurse reviewed Mr Mellors. She noted that he was not sure why he had been referred because he had no mental health issues. He told her that he was prescribed antidepressants 18 years ago, and took them for three years but had no issues with his mood and no thoughts of harming himself. She noted that Mr Mellors did not talk about his offence and was pleasant in his manner. She also noted that Mr Mellors did not require input from the mental health in-reach team and discharged him from the service.

48. The nurse said that she did not conduct a mental health assessment because Mr Mellors told her he did not have a history of mental health problems, had no intention to self-harm and had support. She told the investigator that she would not conduct a full mental health assessment where the prisoner said things that indicated they were not at risk of harm and they had no history of mental health problems.

49. The same day, HM Prison and Probation Service (HMPPS) told Nottingham and HMP Manchester that Mr Mellors was a category A prisoner and would be transferring to Manchester.

Transfer to HMP Manchester

50. On 7 February, HMPPS issued a movement order for Mr Mellors to transfer to Manchester.

51. Around lunchtime, a prison manager at Nottingham took Mr Mellors to reception. The manager said that there was some confusion about whether Mr Mellors'

ACCT was open or closed, but he thought that it was open because this was what was recorded on NOMIS (the electronic prison record). He told the investigator that he could not remember seeing the front of the ACCT document or the 5 February case review, which both noted that it was closed. He said that he skimmed the ACCT document and decided to hold a quick case review to see if there were any issues to address and to ask Mr Mellors if he needed anything. He said he did not speak to anyone about Mr Mellors' ACCT document to clarify its status. He told the investigator that he thought the staff who had arranged the transfer would have told Manchester about Mr Mellors' risk factors.

52. A Supervising Officer (SO) from Manchester said that Mr Mellors was waiting in Nottingham reception when he arrived with two other officers to collect him for transfer. A prison manager told him that Mr Mellors' ACCT document had been closed three days before and they were going to carry out the post-closure review. The SO could not remember the name of the prison manager. The manager said that he remembered speaking to staff from Manchester that day but could not remember what he had told them.

53. The manager and a nurse held an ACCT case review. The manager noted that Mr Mellors had no thoughts of self-harm and his only concern was about the length of travel. Mr Mellors said that he felt cold so the manager noted he would try and find him a top to wear. The nurse noted that Mr Mellors was relaxed and interacting well before his transfer. They assessed his risk as low and ticked 'yes' to indicate that the frequency and observations, conversations and recording requirements were reviewed. Mr Mellors had not been observed since the ACCT was closed on 5 February. They did not hold a post-closure review.

54. The nurse told the investigator that she thought Mr Mellors was on an open ACCT. She said that Mr Mellors was on a controlled drug called zomorph (strong pain relief medication), so she called Manchester and spoke to a nurse there who agreed to take responsibility for this medication when Mr Mellors arrived. The nurse at Nottingham said that she could not remember if she told the nurse at Manchester that Mr Mellors was on an ACCT but she noted the case review in his medical record.

55. The SO said that he was not asked to attend what he thought was a post-closure review. When Mr Mellors returned to the reception area, he told him that he was transferring to Manchester, asked him if he had any problems and whether he was happy to come. The SO said that Mr Mellors was fine. At 2.00pm, Mr Mellors was taken onto the escort van and was transferred to Manchester.

HMP Manchester

56. At 4.30pm, Mr Mellors arrived at Manchester and was taken to reception. A nurse in reception assessed Mr Mellors. The nurse told the investigator that he heard an officer in reception being told by another officer that Mr Mellors had been on an ACCT that had been closed and a post-closure review had been held, but said that nobody had spoken to him about this directly. The SO told the investigator that he spoke to the nurse in reception and told them that Mr Mellors' ACCT document had been closed three days ago and that Nottingham staff had held the post-closure review just before his transfer. The SO said that he handed

the ACCT document along with the rest of Mr Mellors' paperwork to reception staff.

57. The risk indicator section of Mr Mellors' PER form noted that he had driven his car into a tree and had been charged with a second murder. The nurse told the investigator that he did not have the ACCT document or Mr Mellors' PER form when he assessed him. He also said that he could not access Mr Mellors' prison record on the computer that was in the reception screening room. The nurse said that he could not review Mr Mellors' medical records while completing the reception screen because he needed to complete this before the system would allow him to review his previous notes.

58. The nurse said that prisoners who transfer to Manchester from another prison receive a brief reception screening, while prisoners who come from police custody receive a more comprehensive screening. The nurse noted that Mr Mellors said that he had no mental health problems and no suicidal thoughts. He also noted that he had been on an ACCT that had been closed recently and he felt fine now. The nurse also recorded that there had been no self-harm behaviour in the past three months and no suicide attempts in the past six months. He noted that there was no suicide risk and Mr Mellors was not experiencing what he perceived to be a significant life event. The nurse said that Mr Mellors was calm, relaxed, engaged well and did not show any signs of mental disorder. He did not refer Mr Mellors to the mental health team.

59. A nurse in the healthcare unit completed a healthcare screening assessment. She noted that Mr Mellors was not being managed under ACCT procedures, had no suicidal thoughts and no history of an ACCT, attempted suicide or self-harm behaviour in the past three months. She also noted that Mr Mellors was not experiencing what he saw as a significant life event. The nurse noted that Mr Mellors had limited mobility and might need help with his personal care. A nurse prescriber noted there were mixed entries in Mr Mellors' medical record about the amount of help he required and that she would arrange for his mobility to be assessed. Mr Mellors was located in the enhanced care suite in the healthcare unit (this cell is for prisoners with mobility problems and is larger to accommodate a wheelchair and contains a hoist).

60. A nurse, in the course of reviewing the medical notes of prisoners who had come to the healthcare unit that day, noted that a nurse at Nottingham had made an entry saying that Mr Mellors was on an open ACCT document.

61. At approximately 12.15am, a nurse spoke to an officer and told him that she could not find the ACCT document although Mr Mellors' prison record also noted that the ACCT document had not been closed. The officer asked the nurse to open a new ACCT document for Mr Mellors. The nurse noted that Mr Mellors should be observed four times during the night.

62. The next morning at handover, the nurse told nursing staff that they had restarted ACCT procedures and that Mr Mellors would need an ACCT assessment or an ACCT review.

63. When an SO arrived that morning, staff told him that ACCT procedures had been started for Mr Mellors overnight. He was concerned about this because he had

been told by staff at Nottingham that the ACCT had been closed. The SO collected Mr Mellors' ACCT document from the administration area. He said that the front of page and the case review notes indicated that it had been closed but he could not find the post-closure review. An officer said that just before he finished his shift, the SO told him that the ACCT document had been closed. The SO also spoke to an officer about what had happened and gave him the ACCT document from Nottingham.

64. An officer held a post-closure review with Mr Mellors. He asked Mr Mellors how he was feeling and he said he had no thoughts of suicide or self-harm and did not know why the ACCT was opened in the first place. The officer asked if he had spoken to his friends or family and Mr Mellors said he had not because he did not have any phone numbers approved on the prison phone system yet. Mr Mellors said that he had been recalled to prison but could not understand why he had been made a category A prisoner. The officer said he was not sure if Mr Mellors had any concerns about this but he did not seem upset. He asked Mr Mellors to complete the post-closure review questionnaire but Mr Mellors said he found this difficult because of his injuries so he dictated his answers to him. The officer closed the ACCT document.

65. On 9 February, a nurse spent two hours speaking to Mr Mellors and encouraged him to move around on his own. She tried to get Mr Mellors to stand and lift his legs onto the bed but Mr Mellors said he could not do this. She reassured Mr Mellors and asked if he had lost confidence since the accident. Mr Mellors said he had not and the nurse noted that he looked like he was going to become tearful but did not cry. She spoke to Mr Mellors about removing his back brace and said they would practise moving again the next day.

66. The next day, the nurse spent another two hours with Mr Mellors encouraging him to become more independent with his movement. Mr Mellors said that he had lost his confidence and was scared. The nurse reassured him that staff were there to offer support and guidance. Staff continued to help Mr Mellors with moving independently.

67. On 11 February, the nurse told Mr Mellors that he needed to get out of bed. Mr Mellors spoke about his daughter (whose mother was the victim of Mr Mellors' first murder offence). The nurse asked if she knew that he was in prison but Mr Mellors said she did not and that their relationship was not the same as it had once been. He told her that he used to speak to his daughter every week but now it was once a month.

68. On 15 February, Mr Mellors told the nurse that he kept seeing images of his victim's face and said, 'You know I've done it before'. The nurse said that Mr Mellors was sobbing intermittently and told her that he kept having images of the last seconds of the road accident that he was unable to get out of his head. She asked if he was having images of the previous murder as well but he said, 'No, just the one a few weeks ago.' Mr Mellors said that he was feeling 'numb' and that he wished it had never happened. She asked Mr Mellors he if he was trying to punish himself but he said he was not. She told him that it was important to speak to staff who could offer support. He said that he found this difficult. She asked if Mr Mellors felt low in mood but he said he had been depressed before

and it was not that. Mr Mellors said that it was just the images of the accident and he wanted them to go away, and if he squeezed his eyes tight shut, they sometimes did.

69. The nurse asked Mr Mellors he if thought it would help to speak to a mental health nurse or a psychiatrist but he said no. Mr Mellors said that he did not have any thoughts to harm himself so the nurse encouraged him to focus on improving his mobility and to keep talking about his thoughts and feelings. Mr Mellors said that he would try to do this.

70. On 17 February, a healthcare assistant spent an hour helping Mr Mellors to walk. She noted that he was in a quiet mood and asked if he wanted to talk about anything, but he said he was okay and did not need anything.

71. On 18 February, a healthcare assistant noted that she had spoken to Mr Mellors about his progress and how far he had come in the past few days. Mr Mellors spoke to her about his daughter and told her that they normally kept in touch through Facebook.

72. On 20 February, when a nurse spoke to Mr Mellors about removing the wheelchair from his cell, he became extremely distressed. She noted that Mr Mellors started to hyperventilate, squeezed his eyes shut, flexed his elbows and clenched his fists to his chest. Mr Mellors then started wailing and shaking his arms. She tried to get Mr Mellors to calm down using breathing exercises but he wailed and said that he had pins and needles in his whole body and could not move his arms or legs. He kept shaking and holding his arms to his chest for approximately 30 minutes. Mr Mellors eventually stopped but when the nurse asked him to move from his wheelchair into the armchair, he started wailing again and shouted, ‘Argh, it’s coming back’ and clenched his fists and arms to his chest and said he could not move. She told Mr Mellors that she would leave his cell and come back when he had calmed down. He subsequently said he had had a panic attack and that a similar thing had happened to him years ago. The nurse told him that she thought the panic attack related to removing his wheelchair. Mr Mellors said this was not the case.

73. On 22 February, the nurse asked Mr Mellors why he did not want to improve his mobility and again he said, ‘You know what I’ve done.’ He told her that he continued to see his victim’s face and it was haunting him and he wanted it to stop. She suggested speaking to the psychiatrist who might be able to lift his mood and reduce the images. Mr Mellors told her that he did not want to speak to a psychiatrist. The nurse said that she did not think that Mr Mellors felt remorseful over his offence but just wanted the images to go away. She said that he was not emotional when he spoke about it and was talking normally.

74. On 23 February, Mr Mellors asked to have his wheelchair back but the nurse said this would not help him to progress. Mr Mellors said that he had not brushed his teeth for four days and had not showered in six days and when the nurse asked why, he said it was because he could not get to the sink. The nurse said there was no reason why he could not do this and said he could use a chair to shower.

75. On 24 February, the nurse noted that Mr Mellors was not following the physiotherapist’s plan. Later that afternoon, a healthcare assistant noted that Mr

Mellors had been on association and was asked if he would like to join in and play cards but he said no and went back to his cell.

76. At around 7:00pm, an officer saw Mr Mellors lying in bed watching TV in his cell. The officer told the investigator that he walked past Mr Mellors' cell a few times during the night and that he was watching his TV into the early hours of the morning. The officer said he was not sure what time Mr Mellors had turned his TV off but thought it was between 4.00am and 5.00am.

Events of 25 February

77. At around 7.10am, an officer looked into Mr Mellors' cell and said that she saw him getting out of bed. She said that she did not speak to Mr Mellors but could see into the cell as it was quite light.

78. At around 8.40am, another officer went into Mr Mellors' cell to do his morning check. He said that Mr Mellors was usually in bed but he could not see him there so he looked in the toilet area of the cell. He said he saw Mr Mellors standing near the hoist with a ligature around his neck, made from the hoist cord. He called out to staff and ran to support Mr Mellors' weight.

79. Other staff arrived promptly. Another officer supported Mr Mellors' weight. The officer who found Mr Mellors said that his pouch with his fish knife had broken that morning so he borrowed the other officer's fish knife and cut the ligature from Mr Mellors' neck. The officer said that Mr Mellors' face was black and there was blood coming from where he had tied the ligature. He said that it was clear to him that Mr Mellors had died.

80. A nurse was getting ready to give out the morning medication when she heard shouting in the corridor. She went to Mr Mellors' cell and saw him on the floor. She said that he was purple from his nose down to his hands and his tongue was sticking out. The nurse told the officers that they would not be resuscitating him and that they should call an ambulance and tell them that he had died.

81. At 8.44am, a prison manager told the control room that Mr Mellors had been found hanging and had died. At 8.48am the control room called an ambulance. Paramedics arrived at 8.52am and at 9.02am, recorded that Mr Mellors had died.

Events after Mr Mellors' death

82. After Mr Mellors had died, the police found a letter in Mr Mellors' cell from a family member. The letter was postmarked 6 February 2018 and was addressed to Mr Mellors at Nottingham. It is unclear when he received the letter and the prison do not have a record of when Mr Mellors received it.

83. Mr Mellors' family member wrote that she was glad that her mother was no longer with them because when she had heard what he had done she knew her mother would not have survived this. She said that he probably 'couldn't give a damn' as a selfish, self-obsessed person and that she hoped they sentenced him to life and it meant life. She said that if she could influence the sentencing in any way, that she and the rest of the family would do so.

Contact with Mr Mellors' family

84. At 2.00pm on 25 February, a duty governor and a chaplain broke the news of Mr Mellors' death to his brother at his home. The prison offered to contribute to the cost of Mr Mellors' funeral, in line with national instructions.

85. Mr Mellors' brother told the PPO's family liaison officer that the family liaison officer from the prison was 'fantastic' and said he could not praise him highly enough for the support he had provided in difficult circumstances.

Support for prisoners and staff

86. A number of staff who found Mr Mellors said that there was no debrief session after he died. The officer said that a few staff got together and talked about what had happened but he did not think it was an official debrief. The officer said that the staff care team offered support.

87. The nurse said that she was in shock but had to keep working as she was the only healthcare staff member available as she had to send the healthcare assistant home because they were upset. She said she needed to give prisoners their morning medication and was lucky not to have made a mistake because she was upset. She told the investigator that she was given a message that her manager would not be coming in, but she could call them at home if she needed to. She said she felt overwhelmed with everything she was doing and said that she felt abandoned.

88. The prison posted notices informing other prisoners of Mr Mellors' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Mellors' death.

Post-mortem report

89. We have not received a copy of the post-mortem report at the time of writing this report.

Findings

Management of the ACCT process

90. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, outlines a number of risk factors including relationship instability, recall to custody, early days in custody, being charged with a violent offence against a partner and a previous suicide attempt. All of these applied to Mr Mellors.

91. Staff appropriately began ACCT suicide and self-harm prevention procedures as soon as Mr Mellors arrived at Nottingham. However, we have concerns about the management of the ACCT process, including the assessment and management of risk, caremap actions and effective transfer of information.

92. A particular concern is that staff at Nottingham and Manchester were confused about whether Mr Mellors' ACCT document was open or closed. As a result, staff did not have consistent information available in making effective decisions about Mr Mellors' risk of suicide and self-harm and providing continuity in his management.

Assessment and management of risk

93. Prison Service Order (PSO) 1700, Segregation, states, 'Segregation should be used only as a last resort.' PSI 64/2011 states that prisoners on open ACCT plans must only be located or retained in segregation units in exceptional circumstances and that the reasons for segregation must be clearly documented and include the other options that were considered but discounted. Although it was not optimal that Mr Mellors was held in the segregation unit while on an ACCT, we recognise that Nottingham was faced with a difficult decision about where to locate him because of his security status. We consider, on balance, that the decision to segregate Mr Mellors was justified and make no recommendation.

94. At both Nottingham and Manchester, staff relied on Mr Mellors' presentation in assessing his risk of suicide and self-harm and managing his level of risk, rather than on his known risk factors. In particular, we have concerns about the decision to close the ACCT document before his transfer at Nottingham, and in holding the post-closure review at Manchester. We are also concerned that when Mr Mellors spoke about some of his concerns at Manchester, staff did not consider starting ACCT procedures.

The closure of the ACCT document

95. PSI 64/2011 states that ACCT Plans must not be closed within 72 hours of a planned transfer. Transfers between prisons may increase the risk of suicide or self-harm in the early days of a new prison. In February 2016, we published a Learning Lessons Bulletin about Early Days and Weeks in Custody, which highlighted that a significant number of self-inflicted deaths occur within the first 30 days of custody, with the most common theme being that staff fail to identify factors that increase a prisoner's risk of suicide or self-harm. The bulletin also identified that those whose initial time may be more disrupted are particularly at risk.

96. When Mr Mellors arrived at Nottingham on 1 February, staff were aware that he was a potential category A prisoner and would be transferring to a category A prison. A prison manager said that he thought that Mr Mellors would be transferring that week.

97. A nurse said that staff decided on 2 February, that the ACCT should remain open because Mr Mellors was an 'unknown quantity'. She said that 'although he said he was fine, this did not mean that he was okay' and given the seriousness of his offence, 'you ask yourself the question at some point along the journey does the reality hit and does that change peoples' risk'. She said that she was not concerned about Mr Mellors but he was 'not somebody that I would just dismiss'.

98. Nevertheless, on 5 February, after Mr Mellors told staff that he saw no reason for the ACCT to remain open, they assessed his risk as low and decided to close the ACCT document. We are concerned that this decision relied too heavily on Mr Mellors' presentation rather than his known risk factors which remained unchanged and had not been properly addressed. He had not been assessed by the mental health team when the ACCT was closed.

99. We are of the view that the ACCT should have remained open until Mr Mellors had transferred to Manchester. We make the following recommendations:

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

- **The assessment of risk takes account of all the prisoner's circumstances and risk factors and not just their personal presentation.**
- **ACCTs are not closed where it is known a prisoner will be transferring.**

Transfer of information about risk

100. PSI 64/2011 states that where a transfer takes place within the post-closure period, the receiving prison must be informed about the recent ACCT and the need for them to undertake the post-closure review. Information sharing is key to delivering safer custody that is coordinated around the needs of the individual.

101. There was confusion between staff at Nottingham and Manchester about the status of Mr Mellors' ACCT document when he transferred to Manchester on 7 February. While the ACCT document indicated it had been closed on 5 February, it remained open on NOMIS and as a result, the prison manager held a case review prior to transfer.

102. The SO who went to collect Mr Mellors from Nottingham said that a prison manager there told him that they were about to hold a post-closure review rather than a case review, so he thought the ACCT had been finalised. The manager at Nottingham said that he could not remember if he told staff from Manchester that the ACCT was open or closed.

103. The manager said there had been some confusion over the status of other ACCT documents at Nottingham. He said that information had been 'lost in translation' with discrepancies between NOMIS, the ACCT register and the operations report.

The manager said that the safer custody team now check across NOMIS, operations report and the ACCT register to determine the status of an ACCT.

104. We consider that the manager should have reviewed Mr Mellors' ACCT document before holding a case review and clarified the status of his ACCT so that accurate information could have been shared with staff from Manchester. We make the following recommendation:

The Governor of Nottingham should review the operation and management of the ACCT process to ensure that information is accurately recorded and that staff share information to provide collaborative care.

Post-closure review

105. PSI 64/2011 states that when a prisoner has been transferred during the post-closure phase, the receiving prison must allocate a case manager and arrange for the post-closure review to take place. The post-closure interview must review the caremap and the progress made by the prisoner since the ACCT was closed. This must be recorded in the ACCT plan. In all cases, the case manager must decide at the end of the post-closure interview whether there needs to be any further reviews and the frequency of them. The closure must be recorded within the case notes section of NOMIS giving a brief summary of the relevant issues.

106. On 8 February, staff at Manchester realised that Mr Mellors' ACCT had been closed but a post-closure review had not been held. A prison manager held the post-closure review with Mr Mellors but he had not previously met Mr Mellors and did not speak to staff at Nottingham about his ACCT document or risk factors. The manager said that he probably looked at the caremap actions at the time but he could not remember. He did not refer to the caremap in the post-closure review form about the caremap and the review was not documented in NOMIS.

107. Mr Mellors told an officer he did not know why the ACCT document had been started or why he had been made a category A prisoner. The officer said he did not know if Mr Mellors was concerned about becoming a category A prisoner. We are concerned that in determining that no further case reviews were required, the manager relied on Mr Mellors' presentation instead of his risk factors. We make the following recommendation:

The Governor of Manchester should ensure that ACCT post-closure reviews are conducted in line with Prison Service instructions and should be held to check the prisoner's progress and to decide whether further monitoring is needed.

Assessment and management of risk at Manchester

108. PSI 64/2011 states that a prisoner's risk (or likelihood) of self-harm and/or suicide may increase in certain circumstances. There are a number of potential triggers which may increase risk of harm to self or others. Where these triggers are identified as being relevant to a prisoner, appropriate action must be taken, for example, opening an ACCT or referring to the mental health in-reach team. All staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence, and take appropriate action, such as opening an ACCT.

109. On 15 February, Mr Mellors sobbed and told a nurse that he could see his victim's face, kept having images of the last seconds on the accident, said 'You know what I've done' and 'You know I've done it before' and said that he wished it had never happened. On 20 February, the nurse noted that Mr Mellors told her that he thought he had had a panic attack. On 22 February, Mr Mellors again told the nurse that he kept seeing his victim's face which was 'haunting' him and he wanted it to stop. He also referred to his previous offence again saying, 'You know what I've done'. After each of these discussions, the nurse suggested referring Mr Mellors to the mental health team or psychiatrist but Mr Mellors said he did not want to be referred.

110. The nurse said that she did not think that Mr Mellors was depressed and thought that he was not doing things for himself because he liked the attention of staff helping him. She said that when Mr Mellors told her about seeing his victim's face he did not show any signs of distress and mentioned it as they were talking. She said she thought he was the person least likely to kill himself.

111. Mr Mellors' behaviour and comments came against a background of a number of triggers for self-harm and suicide including being charged with a violent offence against a partner, relationship instability, a history of violence, a personality disorder diagnosis, irrational behaviour and physical illness associated with pain and functional impairment. Although the nurse considered referring Mr Mellors to the mental health in reach team and the psychiatrist, she should also have considered opening an ACCT. We make the following recommendation:

The Governor of Manchester and the Head of Healthcare should ensure that staff are aware of, consider and record all known risk factors and triggers for suicide and self-harm and open an ACCT where the prisoner has significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.

Caremap actions

112. PSI 64-2011 states that completion of a caremap is an integral part of the ACCT process. The caremap should give detailed and time-bound actions aimed at reducing the risk posed by the prisoner.

113. Mr Mellors' caremap was poorly articulated and included 'movement issues' and 'physical injuries' and 'lost glasses'. A prison manager told the investigator that 'movement issues' was added to the caremap because Mr Mellors said that he would need help to move and prison staff were concerned about potential litigation because they did not know the extent of his injuries and were worried about doing further damage. This action was not aimed at reducing Mr Mellors' risk of suicide or self-harm.

114. 'Physical injuries' is not a specific or time bound action and it is unclear how this was conceived as a way of managing Mr Mellors' risk of suicide and self-harm. Mr Mellors' lost glasses were added to the caremap because he was worried he would not be able to read. Although an appointment was made for Mr Mellors to see the optician, Mr Mellors remained without glasses when the ACCT was closed.

115. We are concerned that these caremap actions were not aimed at reducing his risk of suicide, were not time bound and were not completed prior to closing the ACCT. Although Mr Mellors' ACCT was started because of the nature of his offence and that he drove his car into a tree, these issues were not noted in his case review discussions and no actions related to these issues were included in his caremap.

Assessing the level of risk and setting the frequency of observations

116. On 2 February, staff assessed Mr Mellors' risk as low and set his observations at once an hour. A nurse said that they had assessed Mr Mellors' level of risk as low because he was located in the segregation unit. She said that there was a lot more intensive observation of somebody in the segregation unit and if he was on normal location, it might have been a different outcome in terms of risk and the frequency of observations.

117. We are concerned that the frequency of observations did not reflect Mr Mellors' level of risk. The nurse said that he was an unknown quantity. He had only arrived at Nottingham the day before after being charged with the murder of his partner and after running his car into a tree a few days earlier. We make the following recommendations:

The Governor of Nottingham should ensure that:

- **ACCT caremaps have specific, meaningful and time bound actions, aimed at reducing prisoners' risks to themselves, progress should be considered at each review and the caremaps updated if additional needs are identified.**
- **Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations which reflects that risk.**

Reception screening at Manchester

118. PSI 07/2015 states that all newly arrived prisoners must be assessed as part of the reception health screen process to determine whether they are at risk of suicide or self-harm. PSI 7/2015, *Early days in custody, reception in, first night in custody, and induction to custody*, states that staff should examine all forms, including person escort records and suicide and self-harm warning forms, when they are received. It requires that all relevant information about the prisoners should be noted in the appropriate record and forwarded to other staff as necessary and any action taken recorded.

119. The nurse who assessed Mr Mellors in reception told the investigator that there is not always time to review a prisoner's medical record before starting a reception screening. He said entering a prisoner's number into the medical record brings up a reception screening template and the medical record cannot be reviewed until this template has been completed. It is only after completing the reception screen that the prisoner's medical record be reviewed to address concerns about a prisoner.

120. The nurse said that it is not possible to check a prisoner's prison record in reception because the room that is used for screenings does not have a computer that allows access to NOMIS. The nurse said that he did not have any concerns about Mr Mellors or consider referring him to the mental health team.

121. The nurse said that he did not see Mr Mellors' ACCT document or PER and recorded that Mr Mellors had no history of a previous ACCT or of self-harm, although he told the investigator that he overheard an officer say that Mr Mellors was on a recent ACCT.

122. As a consequence, the nurse did not know that Mr Mellors had been charged with the murder of his partner when he assessed him or that he had driven his car into a tree. He said that he would have referred Mr Mellors to the mental health team if he had known. The nurse said that he now realises how important information is when a prisoner arrives at the prison and that it might be better to delay the screening until staff have gone through all relevant information. He also said that he has become more vigilant in referring prisoners to the mental health team when he has any concerns.

123. It is vital that healthcare staff in reception have all available information when assessing prisoners. Reception staff should have been aware of Mr Mellors' risk factors but there is no evidence that they were properly considered. We make the following recommendation:

The Governor and Head of Healthcare at Manchester should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm.

Mental health

124. Although Mr Mellors had been charged with the murder of his partner and had a prior diagnosis of anti-social personality disorder, he did not have a mental health assessment while he was at Nottingham or Manchester. At Nottingham, a nurse said that she would not carry out a full mental health assessment if a prisoner said things that indicated they were not at risk of harm and they had no history of mental health problems. She did not note that Mr Mellors had been diagnosed with anti-social personality disorder.

125. The nurse told the investigator that the normal process at Nottingham where there is a risk of suicide or self-harm would be to refer the prisoner to the mental health team for a full assessment. She said that while she was not concerned about Mr Mellors, he was not someone she would dismiss.

126. A full mental health assessment would have provided the opportunity to assess Mr Mellors' risk and try to engage with him and discuss his offence. We make the following recommendation:

The Head of Healthcare at Nottingham should ensure mental health assessments take into account all relevant information, including any previous mental health diagnosis, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines.

127. When Mr Mellors arrived at Manchester, the nurse did not refer Mr Mellors for a mental health assessment because he did not know about his offence and did not review his PER, his prison record, his ACCT document or his medical records. A prison manager told the investigator that after the post-closure review he expected that Mr Mellors would be reviewed by the mental health team given his offence but thought this would be arranged by the nurses in the healthcare unit. A nurse suggested to Mr Mellors that he speak to the mental health team but she did not refer him. We consider that Mr Mellors should have been referred to the mental health team at Manchester and make the following recommendation:

The Head of Healthcare at Manchester should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate, and make a referral when indicated.

Emergency response codes

128. PSI 03/2013 'Medical Emergency Response Codes' states that all staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. Not all healthcare staff at Manchester understood the meaning of emergency response codes and a nurse told the investigator that a code red meant someone's immediate life was at risk and a code blue was a general call for assistance. We make the following recommendation:

The Head of Healthcare at Manchester should ensure that all staff have training in emergency call signs.

Support for staff

129. PSI 64/2011 states that In line with PSI 08/2010 'Post Incident Care' a 'hot debrief' must be held immediately after the all deaths in custody. All staff directly involved in the incident, including Healthcare staff, should be invited. The purpose of the debrief is to acknowledge what happened, acknowledge the role of the staff involved, normalise the situation and ensure that immediate needs of the staff have been met.

130. The officer who found Mr Mellors and the nurse who responded said that they did not attend a debrief session after Mr Mellors' death. The nurse said she was not able to stop work after Mr Mellors was found and had to give prisoners medication while she was upset. Her manager did not contact her and she said she felt 'abandoned.' We make the following recommendation:

The Governor and Head of Healthcare at Manchester should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.

Previous PPO recommendations and prison actions

131. In our investigations into the deaths of two other prisoners at HMP Nottingham we recommended that staff assess a prisoner's risk of suicide and self-harm based on all available information and known risk factors and not just on a prisoner's presentation. Nottingham's action plan for one of the prisoners noted that weekly management checks would be introduced to monitor staff's assessment of risk and the action plan for the other prisoner noted that a review

of ACCT processes that started in July 2017 would be completed in September 2017.

132. In our investigation into the death of another prisoner at Nottingham we made recommendations about setting and recording appropriate levels of observations and considering information from all sources and recording all known risk factors. The clinical reviewer in that case found that the standard of mental health care was not equivalent to that which would be received in the community and we recommended that the Head of Healthcare, healthcare commissioners and governor should review the mental healthcare provision at the prison. Nottingham's action plan noted that an ACCT case management model would be implemented and mental health services would be reviewed by March 2018.

133. Another prisoner died at HMP Manchester on 13 September 2016. One of our recommendations was that staff consider and record all known risk factors when determining risk of suicide, including PER and other sources. Manchester's action plan indicated that the prison would produce and implement clear local guidance for the identification and recording of all risks and triggers by June 2017. More recent PPO investigations where the final report is yet to be issued have also raised concerns about recording, sharing and considering information about risk, identifying the need for mental health referrals and the use of emergency response codes.

134. The similarities between these deaths and that of Mr Mellors suggest that more sustained and effective action is required from Nottingham and Manchester to address our concerns. In light of the troubling similarities between these investigations, we make the following recommendation:

The Executive Director for the Long-Term and High Security Estate and the Prison Group Director for the East Midlands should assure themselves that meaningful action is taken to address our recommendations.

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