

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ben Kelbie a prisoner at HMP Manchester on 4 January 2018

A report by the Prisons and Probation Ombudsman

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 Ben Kelbie was found hanged in his cell on 4 January 2018 at HMP Manchester. He was 32 years old. I offer my condolences to his family and friends.

Staff at Manchester were aware that Mr Kelbie feared for his safety in the prison, and took some action to address this. However, we are concerned that there was too little focus on the impact this had on his risk of suicide and self-harm and no one appeared to consider whether it would be appropriate to start suicide and self-harm prevention procedures.

It is also of concern that, despite being prescribed antipsychotic medication for several years, no one at Manchester referred Mr Kelbie to the mental health team and he was not assessed by them at any point during his time at the prison.

Like many prisoners, Mr Kelbie used psychoactive substances and we continue to be deeply concerned by their prevalence in prisons. We are also concerned that, despite previous recommendations by this office, the officer who responded to Mr Kelbie's hanging did not use an appropriate medical emergency response code. We hope that meaningful action will be taken to address this continuing operational deficit.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

September 2018

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Summary

Events

1. Mr Ben Kelbie was remanded to HMP Forest Bank in June 2017. He had taken antipsychotic medication for several years, having been diagnosed with a psychotic illness in 2003. Following a court appearance on 23 October, he was transferred to HMP Manchester, where a healthcare assistant noted Mr Kelbie's diagnosis and medication. She did not refer him to the prison's mental health team.
2. On 23 December, prison staff found Mr Kelbie under the influence of psychoactive substances (PS). They referred him to the substance misuse team. Mr Kelbie's cellmate told us that he smoked PS every day and was in debt to other prisoners as a result.
3. On 3 January, Mr Kelbie told an officer that he wanted to move to another wing because he was in debt to another prisoner on his wing. On 4 January, another officer told Mr Kelbie that she had arranged for him to move, and that it would happen later that afternoon or the next day.
4. Mr Kelbie's cellmate told us that at around 3.00pm he went into the toilet recess of the cell and said he would "do himself some harm". His cellmate told us that Mr Kelbie had said similar things before but had not harmed himself. At 3.34pm, another prisoner went to the cell door to speak to Mr Kelbie. When his cellmate went to fetch Mr Kelbie, he found him hanging from a ligature. The other prisoner fetched a member of staff who opened the cell, called for assistance and, with a colleague, removed the ligature. Other staff began chest compressions but paramedics confirmed Mr Kelbie's death at 3.58pm.

Findings

Identifying risk of suicide and self-harm

5. Mr Kelbie was seemingly anxious and fearful for his safety during the last 24 hours of his life. While prison staff took some action to address this, we found little evidence that they considered the impact this had on his risk of suicide and self-harm or considered whether to start Prison Service suicide and self-harm prevention procedures, known as ACCT.

Staff-prisoner relationships

6. There was little evidence of any meaningful interaction between prison officers and Mr Kelbie, and he spent much of his time locked in his cell. This meant that prison staff had less opportunity to identify his illicit drug use or any other underlying issues he had. Manchester will soon begin implementing a new offender management model, which we hope will increase meaningful engagement between staff and prisoners.

Psychoactive Substances

7. Mr Kelbie frequently used PS. It is a continuing concern that these drugs are widely prevalent in prisons, including the High Security estate and that Mr Kelbie was apparently able to obtain them easily.

Mental health referral

8. Mr Kelbie had taken antipsychotic medication for a number of years when he was transferred to Manchester. He was not referred to the mental health team either on arrival at the prison or at any other time.

Emergency response

9. The response of prison staff when Mr Kelbie hanged himself was mostly effective. However, the officer who radioed for assistance did not use the appropriate medical emergency code, which meant that an ambulance was not called immediately as it should have been. It is disappointing that we have raised this issue in several previous investigations at Manchester.

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 recommendations and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.
- The Governor should ensure that there are effective supply and demand reduction strategies to help eradicate the availability of PS and that staff are vigilant to signs of its use and take appropriate action.
- The Head of Healthcare 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 Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded. He obtained copies of relevant extracts from Mr Kelbie's prison and medical records.
11. The investigator interviewed 15 members of staff and two prisoners at Manchester in February.
12. NHS England commissioned a clinical reviewer to review Mr Kelbie's clinical care at the prison.
13. We informed HM Coroner for Manchester of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Kelbie's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Kelbie's mother and sister said that he had told them that he was being bullied and had been attacked both on the night before and on the day of his death. They asked the following questions:
 - How the alarm was raised when Mr Kelbie hanged himself, by whom, and what actions his cellmate took at this time;
 - Whether Mr Kelbie was assessed and treated for mental ill health; and
 - Whether prison staff were aware that Mr Kelbie was being bullied or had been attacked.
15. The initial report was shared with HM Prison and Probation (HMPPS). They did not find any factual inaccuracies.
16. Mr Kelbie's mother received a copy of the initial report. She did not find any factual inaccuracies.

Background Information

HMP Manchester

17. HMP Manchester operates as both a high security prison and as 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 provide 24-hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

18. The most recent 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.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report 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. They also reported that the use of PS was an issue within the prison.

Previous deaths at HMP Manchester

20. Mr Kelbie was the sixteenth of 20 prisoners to die at Manchester since January 2015, the sixth of eight prisoners to take their own life during this period. In a number of our previous investigations, we reported that prison staff did not radio an emergency code when they identified a potentially life-threatening situation. Our report into the death of a man in September 2016 found that there was little meaningful interaction with the man during his time at the prison.

Assessment, Care in Custody and Teamwork

21. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. 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.

Psychoactive Substances

22. PS (formerly known as 'new psychoactive substances' (NPS) or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
23. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time, NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
24. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

25. Mr Ben Kelbie was sent to prison several times between 2003 and 2013. In 2003, a psychiatrist diagnosed him with a “psychotic illness”, after which he was prescribed olanzapine (antipsychotic medication). In 2010, he cut his arms with a razor blade, and prison staff managed him under ACCT procedures for five days. In 2013, a community psychiatrist assessed Mr Kelbie and concluded that he likely experienced paranoid schizophrenia (a mental illness in which patients often experience hallucinations, usually in the form of hearing voices, and paranoid delusions about other people intending to do them harm).
26. After his release from a short prison sentence in 2013, Mr Kelbie lived in the community for several years. His community medical records do not highlight any treatment for his mental ill health, other than the continued prescription of olanzapine.
27. On 20 June 2017, Mr Kelbie was remanded to HMP Forest Bank, charged with various offences, including assaulting his former partner.

HMP Forest Bank

28. A nurse assessed Mr Kelbie shortly after he arrived at Forest Bank. He recorded that Mr Kelbie was prescribed olanzapine and that he described his diagnosis as “depression with psychotic episodes”. Mr Kelbie said he had never harmed himself and did not feel like doing so.
29. A prison GP then assessed Mr Kelbie. He recorded that Mr Kelbie said he had taken antidepressants for one month and was prescribed olanzapine because of “psychotic episodes”. Mr Kelbie also told the GP he had seen a psychiatrist in the community. The GP prescribed olanzapine but did not prescribe an antidepressant.
30. On 21 June, an officer spoke to Mr Kelbie about the self-harm recorded in his prison records from 2010. Mr Kelbie again said that he had no current thoughts of harming himself.
31. On 23 October, Mr Kelbie attended Crown Court. He was convicted and sent to HMP Manchester to await sentencing.

HMP Manchester

32. A healthcare assistant assessed Mr Kelbie when he arrived at Manchester. She recorded that he took olanzapine and said that he had a history of psychosis. She concluded that Mr Kelbie was not at risk of suicide or self-harm. She told us that she could not remember Mr Kelbie, but based her judgements on a prisoner’s body language, interaction and maturity. The healthcare assistant referred Mr Kelbie to the prison doctor but not to the mental health team. She told us that she did not refer Mr Kelbie to the mental health team because his mental ill health appeared stable at the time.
33. Later that evening, a prison GP prescribed olanzapine. He recorded that Mr Kelbie would have a follow-up appointment with a psychiatrist. This did not happen.

34. On 24 October, an officer conducted a 'day two' interview. She recorded that Mr Kelbie told her that he had no thoughts of suicide or self-harm. A prison chaplain also spoke to Mr Kelbie and recorded that he had no thoughts of harming himself.
35. On the same day, a prison GP assessed Mr Kelbie's fitness to keep his medication in-possession in his cell. He concluded that Mr Kelbie was suitable for this, and recorded that his risk of suicide was low. He told us that he based his judgement on a range of factors, including whether there was a history of self-harm, substance misuse, bullying or mental health issues.
36. Mr Kelbie moved to B Wing on 25 October. In November, he twice tried to contact his ex-partner, who was the victim of his offences and whom he was not permitted to contact. On both occasions, prison staff administered warnings about his Incentives and Earned Privileges (IEP) level. (The IEP scheme aims to encourage and reward responsible behaviour in prisons.)
37. On 11, 14 and 20 December, Mr Kelbie did not attend his job in the prison kitchens. As a result, he lost his job and prison staff administered a further IEP warning. No one recorded that they had spoken to Mr Kelbie to establish why he had not attended work.
38. On 14 December, Mr Kelbie began to share a cell. His cellmate told us that Mr Kelbie coped well with prison. He told us he did not know if Mr Kelbie used drugs or had any associated problems such as debt or bullying.
39. On 23 December, prison staff found Mr Kelbie and six other prisoners under the influence of drugs. A nurse assessed Mr Kelbie and recorded that he had taken PS. She also referred him to the substance misuse team and a healthcare administrator consequently put him on their waiting list. Two officers told us that prison staff twice found Mr Kelbie under the influence of drugs, although there is no record of any other incident in his prison record. None of the other B Wing staff to whom we spoke were aware of any other incident.
40. A Supervising Officer (SO) held an IEP review afterwards, and reduced Mr Kelbie to the basic level of the scheme for 28 days. He told us that this is standard practice for any prisoner found under the influence of drugs.
41. On 27 December, another prisoner moved into the cell with Mr Kelbie. He told us that Mr Kelbie tended to keep to himself. He said that Mr Kelbie smoked 'Spice' (a PS) every day and was in debt to other prisoners for drugs.
42. On 31 December, an SO completed a mandatory review of Mr Kelbie's IEP level. He concluded that Mr Kelbie should remain on the basic level.
43. On 2 January, a prison GP wrote to Mr Kelbie about his recent drug use. He wrote that it would not be safe to continue to prescribe olanzapine if Mr Kelbie continued to use illicit drugs. He added that any further report of Mr Kelbie being under the influence of drugs would result in a review and the potential stoppage of his olanzapine prescription. The GP told us that this was a standard letter sent to all prisoners found under the influence of drugs (other than those whose medication meant that the potential dangers of using illicit drugs were so great that the medication had to be stopped immediately).

44. On the afternoon of 3 January, an officer answered Mr Kelbie's cell bell. Mr Kelbie said that he would like to move to a different wing because he was in debt to someone on B Wing. The officer told Mr Kelbie that the prison's policy was that they would only arrange a wing move if he named the prisoner to whom he was in debt. Mr Kelbie did not initially name a prisoner but, later in the afternoon, called the officer back to his cell and gave him a prisoner's name. The officer told us that he told Mr Kelbie that it was unlikely that he would be able to move wings that day as it was quite late, but he would speak to the duty supervising officer about the matter.
45. Mr Kelbie's family told us that he was assaulted by another prisoner on the evening of 3 January, and again on the morning of 4 January. None of the prisoners or staff to whom we spoke were aware of these incidents. Mr Kelbie was locked in his cell on the afternoon and evening of 3 January.

4 January 2018

46. Officer A told us that an SO asked her at the morning briefing to arrange a wing move for Mr Kelbie because he was in debt. She told us that she was able to arrange a three-way swap that meant Mr Kelbie would move to D Wing. She said that the swap would have happened either later that afternoon or the following day, depending on when there was time.
47. Officer B told us that the SO asked the officers at the morning briefing to leave Mr Kelbie locked in his cell during his association period to protect him from potentially becoming a victim of violence. On B Wing at the time, prisoners who did not work (such as Mr Kelbie) were unlocked to spend time with their peers from 10.00am to 11.00am, and those who worked were unlocked from 3.00pm to 4.00pm.
48. Officer B unlocked the landing at around 10.00am. He told us that Mr Kelbie asked to be unlocked and said that he felt all right now and wanted to come out. He said that he asked Mr Kelbie if he was sure, to which Mr Kelbie replied that he was fine. He therefore unlocked the cell.
49. CCTV footage shows that Mr Kelbie left the cell and landing at around 10.05am, returning at 10.20am. Mr Kelbie spent most of the rest of the association period either in his cell or near it. None of the footage we saw provided any evidence that Mr Kelbie had been assaulted and neither his cellmate nor any of the staff to whom we spoke (including all those who worked on B Wing on 4 January) had any knowledge of this.
50. At 11.03am, Officer A locked Mr Kelbie and his cellmate in the cell. She was at the door for around 30 seconds. She told us that Mr Kelbie asked her if his wing move had been arranged. She told him that it had, and advised Mr Kelbie when the move might happen. (She told us that she thought this conversation happened at around 2.00pm, but CCTV footage shows that she last went to Mr Kelbie's cell at 11.03am.)
51. At around 11.27am, an officer unlocked Mr Kelbie for lunch. After collecting lunch, Mr Kelbie left his cell for around a minute. Mr Kelbie's former cellmate told

us that Mr Kelbie came to his door to ask for an electronic cigarette. An officer locked Mr Kelbie in his cell at 11.29am.

52. At around 2.15pm, an officer went to Mr Kelbie's cell to answer the cell bell. He told us that he could not remember whether he spoke to Mr Kelbie or his cellmate, or what the conversation entailed. The cellmate also said that he could not remember this.
53. The cellmate told us that Mr Kelbie was 'panicking' about his drug debts on 4 January. He said that at around 3.00pm, Mr Kelbie pressed the cell bell but no one answered. (Manchester's records show that the cell bell was not pressed at this time.) He told us that Mr Kelbie then said he would "do himself some harm" and went into the toilet recess of the cell. He told us that Mr Kelbie had said similar things before so he did not think he intended to harm himself. He said that Mr Kelbie was in the toilet recess for around half an hour and he did not hear any sounds during this time.
54. At 3.34pm, Mr Kelbie's former cellmate went to his cell. He told us that he wanted to ask Mr Kelbie if he still needed an electronic cigarette. He said that he asked Mr Kelbie's current cellmate to fetch him. He told us that the cellmate looked in the toilet recess and said Mr Kelbie "did not look right". He said he then asked the cellmate to look again, and when the cellmate returned he made a 'ligature' action with his hand and asked him to fetch an officer.
55. The former cellmate left the cell at 3.35pm and returned with an officer after 16 seconds. (It was now 3.36pm.) The officer told us that the former cellmate appeared agitated and said he "needed to come". CCTV shows that the officer looked in the cell and then shouted up the stairs for assistance.
56. The officer then opened the cell and went into the toilet recess. He found Mr Kelbie hanged from a ligature made from a strip of bed sheet which he had tied to the window bars. He radioed for, "Urgent assistance Hotel 1 and staff required Bravo Wing". (Hotel 1 is the radio call sign for the response nurse.) With the help of a prisoner he then lifted Mr Kelbie to support his weight. Another officer, who arrived at the cell at 3.37pm, cut the ligature and began chest compressions. Staff attached a defibrillator, which found no shockable heart rhythm.
57. At 3.39pm, a nurse arrived and requested an ambulance. The control room operator telephoned for an ambulance immediately. The nurse continued chest compressions until paramedics arrived at 3.52pm. At 3.58pm, the paramedics confirmed that Mr Kelbie had died.

Contact with Mr Kelbie's family

58. A family liaison officer and a chaplain visited Mr Kelbie's mother on the evening of 4 January and told her of his death. Manchester contributed to the costs of Mr Kelbie's funeral in line with Prison Service instructions.

Support for prisoners and staff

59. After Mr Kelbie's death, an operational manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

61. A post-mortem examination found that Mr Kelbie died of hanging. Toxicology tests found that Mr Kelbie had used PS at some point before his death. The post-mortem examination did not identify any significant recent injuries on Mr Kelbie's body.

Findings

Identifying risk of suicide and self-harm

62. Prison Service Instruction (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 Manchester should have recognised Mr Kelbie as at risk and begun ACCT procedures to support him.
63. Mr Kelbie had some risk factors for suicide and self-harm. He had harmed himself in prison before, albeit some years previously. He had told wing staff that he was in debt, and was therefore at risk of violence. There was evidence he had used PS, which can produce a range of reactions and might increase the risk of suicide and self-harm.
64. Staff at Manchester recognised that Mr Kelbie had some issues in his last 24 hours at the prison. They recognised that his safety was potentially at risk and therefore arranged for him to move wings.
65. However, none of the staff considered whether Mr Kelbie's fears for his safety increased his risk of harming himself. Instead, there was a general acceptance that debts and requests for wing moves – particularly in the days before prisoners received their purchases from the prison shop – were a common feature of prison life. In our Learning Lessons thematic report into self-inflicted deaths in 2013-14, we found that staff too rarely considered that a fear of violence and intimidation made prisoners more vulnerable and could increase their risk of suicide. We consider that staff at Manchester should have been more alert to Mr Kelbie's risk factors for suicide and self-harm. While this would not automatically have led them to open ACCT procedures, they should at least have considered it in light of his ongoing risk factors. We make the following recommendation:

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 recommendations and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

Staff-prisoner relationships

66. Mr Kelbie's cellmate told us that he used drugs every day, and was in debt to other prisoners as a result. During his time at Manchester, there were very few entries in Mr Kelbie's case notes, none of which related to his welfare. There is no personal officer scheme at Manchester and, therefore, little opportunity for prisoners to have significant one-to-one contact with staff. This is particularly important for prisoners, such as Mr Kelbie, who do not work or attend education and therefore spend much of the day locked in their cell. While more meaningful contact would not necessarily have identified Mr Kelbie's drug use at an earlier

stage, this was a missed opportunity to recognise this and any other underlying issues he might have had.

67. We are pleased that Manchester is soon to start implementing a new offender management model, part of a national roll-out. This includes every prisoner having a keyworker who will be their first point of contact and assist them with any difficulties they are having in prison. We hope that it will assist in lessening the distress and isolation felt by prisoners like Mr Kelbie in the future. We therefore make no recommendation but record our concern at a troubling lack of meaningful engagement between staff and the prisoners in their care.

Psychoactive Substances

68. Prison staff found Mr Kelbie under the apparent influence of drugs around two weeks before he died, and appropriately referred him to the substance misuse team. Mr Kelbie's cellmate told us that he smoked Spice (a PS) every day, and toxicology tests found that he had used these drugs at some point before his death. HM Inspectorate of Prisons, in their inspection of November 2014, reported that prisoners found it easy to obtain illicit drugs at Manchester.
69. Our Learning Lessons bulletin on PS, issued in July 2015, sets out why these substances have become a source of increasing concern in prisons. There is evidence that PS poses dangers to both physical and mental health. In addition, trading these substances can lead to debt, violence and intimidation. In our annual report for 2016-2017, we noted that the number of deaths, where the use of PS may have played a part, continued to rise and that there was a greater need than ever for more effective drug supply and demand reduction strategies, including better monitoring by drug treatment services and effective violence reduction strategies.
70. It is important that Manchester focuses on the prevalence and dangers of PS and does all it can to eradicate their use. We make the following recommendation:

The Governor should ensure that there are effective supply and demand reduction strategies to help eradicate the availability of PS and that staff are vigilant to signs of its use and take appropriate action.

Mental health referral

71. On arrival at Manchester, Mr Kelbie told a healthcare assistant that he had a history of psychosis, and she noted that he was prescribed antipsychotic medication. In light of this evidence of potentially significant mental ill health, we are concerned that she did not refer Mr Kelbie to the prison's mental health team.
72. The clinical reviewer highlights National Institute for Health and Care Excellence (NICE) guidelines about the health of prisoners. They state that if a prisoner has ever seen a healthcare professional about a mental health problem or ever been prescribed medication for a mental health problem, they should be referred to the mental health team. Mr Kelbie continued to take olanzapine throughout his time at Manchester but was never referred to the mental health team. She concluded that his care was not therefore equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare 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

73. PSI 03/2013 on medical emergency response codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It requires an ambulance to be called immediately if an emergency code is radioed. Staff should ensure that there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.
74. Manchester's emergency response protocol was reissued in November 2017, following several recent investigations in which we reported that prison staff did not radio an emergency code when they identified a potentially life-threatening situation. It instructs the use of emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of circumstances in which staff should use code blue are when a prisoner has difficulty breathing or is unconscious, for instance, after a hanging. The protocol also sets out the expectation that nothing should delay control room staff calling an ambulance on hearing an emergency code.
75. The officer did not radio a code blue. Instead, he requested the urgent assistance of the response nurse. This meant that the control room operator did not request an ambulance until the nurse radioed an emergency medical code around two minutes later. While much of the officer's actions were commendable, it would have been appropriate to radio an emergency code when he had identified that Mr Kelbie had tied a ligature. This would have alerted staff throughout the prison, including the emergency response nurse, and signalled the control room to call an ambulance immediately.
76. It is encouraging that the Governor has taken action to address our previous recommendations. However, these events indicate that there is still work to be done to ensure that all staff are aware of and understand their responsibilities in a medical emergency. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.

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