Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kieron Simpson a prisoner at HMP Manchester on 2 May 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Kieron Simpson was found hanged in his cell at HMP Manchester on 2 May 2018, five weeks before he was due for release. He was 29 years old. I offer my condolences to Mr Simpson's family and friends.

Mr Simpson was monitored under Prison Service suicide and self-harm procedures (known as ACCT) on three occasions at Manchester but was not being monitored at the time he died. The investigation found there was little to indicate that Mr Simpson was at risk of suicide and self-harm in the weeks leading up to his death and that staff could not reasonably have foreseen his actions. However, it identified failings in how the ACCT procedures were managed at Manchester.

There was intelligence to suggest that Mr Simpson was committing acts of violence in exchange for illicit drugs or to repay drug debts. I am concerned that prison staff did not fully investigate this and failed to provide Mr Simpson with adequate support.

The investigation also found that there was an unacceptable delay in responding to Mr Simpson's request to see a doctor for a review of his antidepressant medication, which did not take place before he died.

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

Sue McAllister CB
Prisons and Probation Ombudsman **March 2019**

Contents

Summary

Events

1. Mr Kieron Simpson was moved from HMP Durham to HMP Manchester on 15 June 2017. He was serving a 48-month sentence for the manslaughter of a fellow prisoner in 2015 and was due for release from prison on 10 June 2018.

2. On 22 June 2017, staff started suicide and self-harm prevention monitoring (known as ACCT) after Mr Simpson made cuts to his arm with a razor blade. He was allocated a psychiatric nurse (CPN) and his risk was assessed as low after he said he had no thoughts of suicide or self-harm. Staff stopped ACCT monitoring on 26 June but restarted it the next day after Mr Simpson set fire to his cell.

3. On 5 July, a psychiatrist diagnosed Mr Simpson with an adjustment disorder and prescribed mood stabilisers. Staff stopped ACCT monitoring on 12 July and Mr Simpson was discharged from the CPN's caseload. Mr Simpson stopped taking his medication from 17 July and refused to attend a psychiatrist appointment on 2 August. There was no further input from the mental health team after this, but a doctor prescribed antidepressant medication for Mr Simpson on 3 December.

4. On 17 January 2018, staff started ACCT monitoring after Mr Simpson said he felt suicidal. He was moved to another wing and staff stopped ACCT monitoring on 19 January.

5. On 8 March, a CPN requested a GP appointment for Mr Simpson after he told an officer that he wanted a review of his antidepressant medication. A review did not take place before he died.

6. Mr Simpson was involved in numerous fights with other prisoners and also assaulted staff during his time at Manchester. He also used illicit substances. As a result, he was placed on a basic regime for long periods and was moved to different locations around the prison on at least 20 occasions. On 9 April, an intelligence report suggested Mr Simpson may be carrying out violent acts on behalf of others in exchange for illicit drugs or to repay debts.

7. On 2 May, at approximately 5.00am, an officer was carrying out the morning roll check when he found Mr Simpson hanging from his bed. The officer called for urgent assistance and another officer responded immediately. The control room called an ambulance at 5.05am. The officers cut down Mr Simpson but found that rigor mortis was present and therefore they did not attempt cardiopulmonary resuscitation (CPR). The first medical responder attended shortly afterwards and agreed that CPR would be futile. Ambulance staff arrived at 5.12am and at 5.20am, they pronounced that Mr Simpson had died.

Findings

8. There was no obvious indication of an increase in Mr Simpson's risk of suicide or self-harm after staff stopped ACCT monitoring on 19 January. We consider it reasonable that he was not being monitored under ACCT at the time he died.

9. We found that staff did not appropriately manage the ACCT procedures. There were times when staff failed to complete a caremap, to hold a post-closure review and to reassess Mr Simpson's risk when they reopened the ACCT.

10. We found no evidence that staff investigated the suggestion that Mr Simpson may have been coerced into carrying out violent incidents in exchange for drugs or to repay drug debts.

11. Mr Simpson's request on 8 March to see a doctor for a review of his antidepressant medication, was not actioned before he died. We consider this delay to be unacceptable.

12. The officer who found Mr Simpson hanged in his cell did not use a medical emergency code as he should have done. Although there was no delay in the emergency response, the correct medical emergency procedures should be followed.

13. We found no evidence that staff involved in the emergency response attended a hot debrief immediately after the incident.

14. Our investigation found that at the time of Mr Simpson's death, Manchester had no arrangements in place to manage complex prisoners such as Mr Simpson, who had a history of violence towards others, substance misuse and mental health issues. Manchester has since introduced processes to manage prisoners with complex needs.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that they:
    - complete ACCT caremaps to include specific, meaningful and time bound actions, aimed at reducing prisoners' risks to themselves, consider progress at each review and update the caremaps if additional needs are identified;
    - assess and record risk at each review, especially when an ACCT is reopened, and clearly document the reasons for any change in risk; and
    - hold a post-closure review within seven days of closing an ACCT.
- The Governor should ensure that all incidents of violence are investigated in accordance with PSI 64/2011 and Manchester's own Violence Reduction Policy, including providing feedback on the investigation to the victim and ensuring that details of the investigation are appropriately documented.

- The Governor should ensure that all prisoners have a single named member of staff assigned to them who supports and encourages them to achieve their objectives.
- The Head of Healthcare should ensure that:
  - the appointment allocation system is robust and effective in facilitating GP interventions for patients subject to frequent cell movement around the prison; and
  - prisoners have access to mental health services equivalent to those in the community.
- The Governor and Head of Healthcare should ensure that all staff are aware of the correct medical emergency codes and have appropriate training in the use of emergency call signs.
- The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, that all those involved in the incident are invited to attend, and that an accurate written record of attendees is kept.

The Investigation Process

15. 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.

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

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

18. The investigator and the clinical reviewer interviewed nine members of staff at HMP Manchester. The clinical reviewer separately interviewed one member of healthcare staff. The interviews took place in August 2018.

19. We informed HM Coroner for Manchester of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Simpson's stepfather to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Simpson's stepfather wanted to know if Mr Simpson was being bullied, if he was receiving any support from the mental health team, and what might have led him to take his life so close to his release date.

21. Mr Simpson's family received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.

Background Information

HMP Manchester

22. 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. Greater Manchester Mental Health NHS Foundation Trust provide 24-hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Manchester was in June and July 2018. Inspectors found that levels of violence were significant and two-thirds of prisoners said they had felt unsafe during their time at Manchester. Work to address this was developing and inspectors saw evidence of good data analysis and a casework approach to tackling poor behaviours, although some of this work was relatively new. An impressive multidisciplinary complex case meeting reviewed the management of both perpetrators and victims of violence, but the violence reduction strategy did not consider the negative impact of poor living conditions and boredom on violence and substance misuse. A new unit had been set up aimed at the integration of difficult and challenging individuals but an effective interventionist regime was still to be established.

24. Illicit drugs were a significant problem with 53% of prisoners saying it was easy to get drugs. The overall drug strategy was weak and there was no whole-prison approach to address issues of supply and demand.

25. Inspectors found that the majority of staff were approachable and helpful. However, 53% of prisoners said that they had experienced victimisation by staff and inspectors found that a small but influential number of operational staff were disengaged and demonstrated little respect for prisoners. The absence of personal officers or key workers made it more difficult for staff and prisoners to engage and build constructive, meaningful relationships.

Independent Monitoring Board

26. 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 Manchester for the year to 28 February 2018, the IMB reported concerns about poor prisoner behaviour and the availability of psychoactive substances on B Wing. Despite this, they found an overall reduction in positive mandatory drug tests and a reduction in violence throughout the prison. The IMB commended staff for developing humane, person-centred support within a well-regulated community. They remained concerned about staffing numbers and the impact on prisoner life as well as the poor standard of accommodation and maintenance delays.

Previous deaths at HMP Manchester

27. Mr Simpson was the 18th prisoner to die at Manchester since May 2015. Six of the previous deaths were self-inflicted. There have been three deaths since, one self-inflicted and two from natural causes. Previous investigations have identified

deficiencies in suicide and self-harm prevention procedures and the use of correct medical emergency codes.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

29. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be 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.

30. 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.

Psychoactive Substances (PS)

31. Psychoactive substances (formerly known as 'new psychoactive substances' 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.

32. 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.

33. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Incentives and Earned Privileges (IEP) scheme

34. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell,

the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

35. Mr Kieron Simpson was sentenced to 48 months in prison on 26 May 2015 for the manslaughter of a fellow prisoner while he was detained at HMP Doncaster. He was moved from HMP Durham to HMP Manchester on 15 June 2017. Mr Simpson's Person Escort Record (PER – a document which accompanies prisoners between courts, police custody and prison establishments) indicated that he believed he was under threat from others and that he displayed unpredictable, violent behaviour. His cell sharing risk assessment (CSRA) was assessed as high.

36. The healthcare reception screening was carried out by a healthcare assistant. Mr Simpson was not taking any prescribed medication, he reported no physical or mental health problems, no substance misuse issues and no recent history of self-harm or suicidal thoughts. Mr Simpson was placed in a single cell on A Wing on 16 June.

37. On 22 June, staff started suicide and self-harm prevention monitoring (known as ACCT) after Mr Simpson made cuts to his arm with a razor blade. Mr Simpson said that he was feeling stressed and he wanted to move from A Wing. His first ACCT review on 23 June was chaired by a Supervising Officer (SO) and attended by a psychiatric nurse (CPN) and a student nurse from the mental health team. Mr Simpson said he was looking forward to his release date next year and wanted to settle down into the prison regime and start work. There was no initial assessment of Mr Simpson's risk and no caremap was completed setting out the necessary actions to reduce his risk and work towards closing the ACCT. The nurse recorded in Mr Simpson's medical notes that he had a previous history of self-harm but had no current suicidal thoughts. He also recorded that Mr Simpson said he suffered from anxiety and depression and had previously been prescribed antidepressant medication.

38. Later the same afternoon, staff placed Mr Simpson on report for fighting with another prisoner and submitted an intelligence report.

39. On 24 June, an officer found blades in Mr Simpson's cell and he was placed on basic regime. Staff moved him to D Wing.

40. The second ACCT review was held on 26 June, chaired by a SO and attended by an officer. There was no input from healthcare staff. Mr Simpson said he was settled on D Wing and he had no thoughts of self-harm or suicide. His risk was assessed as low. The SO and the officer agreed to close the ACCT and scheduled the post-closure review for 3 July.

41. On 27 June, Mr Simpson set fire to his cell using a kettle and staff reopened the ACCT. Staff did not reassess his risk or record the reasons for reopening the ACCT. The SO chaired an ACCT review the next day which was also attended by an officer and a psychiatric nurse. Mr Simpson said that things were getting on top of him and he needed to speak to someone about his thoughts of harming others, but he had no thoughts of harming himself. Mr Simpson also said that he was frustrated at being on basic regime and he said he had used psychoactive substances (PS). The nurse noted in Mr Simpson's medical record that he had

taken him onto his caseload and made a referral for a psychiatric assessment. Staff did not complete a caremap.

42. On 5 July, Mr Simpson had a psychiatric assessment with a prison GP. The GP noted that Mr Simpson was having fluctuating moods, difficulties sleeping and had experienced vivid dreams about the prisoner he had killed. Mr Simpson told him that he felt lonely and insecure as he was in a cell on his own and on basic regime. The GP diagnosed an adjustment disorder and prescribed valproic acid (a mood stabiliser). Mr Simpson had an ACCT review later that day. The review was chaired by a SO and attended by an officer, but there was no healthcare input. Mr Simpson's risk was assessed as low.

43. On 7 July, Mr Simpson was moved to the Vulnerable Prisoners Unit (VPU) on E Wing after telling staff that he was being threatened due to drug debts. He remained on basic regime. Mr Simpson told the psychiatric nurse that he was happier now that he was taking his medication and had moved to E Wing.

44. Mr Simpson had an ACCT review on 12 July which was chaired by a SO. The review was also attended by the psychiatric nurse, an officer and the prison chaplain. Mr Simpson said that he no longer needed to be on an ACCT and staff assessed his risk as low. He remained on basic regime but said that he was happier on E Wing. Staff agreed to stop ACCT monitoring and Mr Simpson was discharged from the psychiatric nurse's caseload. However, the nurse noted that Mr Simpson would continue to be seen in the psychiatric clinic. No caremap was completed and a post-closure interview did not take place.

45. On 17 July, Mr Simpson refused his medication saying that he did not like the side effects. A nurse notified the mental health team and Mr Simpson saw a prison GP on 27 July. Mr Simpson told the GP that he no longer wanted to take mental health medication as it did not work. He said his mood was better and he had no thoughts of suicide or self-harm. The GP stopped his medication.

46. On 29 July, staff placed Mr Simpson back on standard regime.

47. On 2 August, Mr Simpson had an appointment scheduled with the psychiatrist but he refused to attend. He said that he was more in control of his mind and did not need any help. The psychiatrist wrote in Mr Simpson's medical record that he refused to attend, he was not on any medication and there was no follow up scheduled. Mr Simpson had no further input from the mental health team.

48. On 6 October, an officer wrote in Mr Simpson's prison record that he was bullying other prisoners on E Wing. Staff submitted an intelligence report and Mr Simpson was removed from the VPU. He was also put on basic regime and moved back to A Wing. He was moved to B Wing on 25 October.

49. On 4 November, staff placed Mr Simpson on report for going onto the netting on B Wing. He also damaged the toilet in his cell and threw food at an officer. He was restrained and taken to the segregation unit. Later that day he was moved back to A Wing.

50. On 7 November, Mr Simpson told staff that he was under threat and did not feel safe. He wanted to be moved back to the VPU. Staff submitted an intelligence report and opened a violence reduction victim support plan. We found no

evidence of any support given to Mr Simpson. His request to be moved back to the VPU was refused and he remained on A Wing.

51. On 10 November, Mr Simpson assaulted another prisoner by punching him in the face. Staff submitted an intelligence report and opened a violence reduction support document to monitor Mr Simpson as the perpetrator.

52. On 19 November, staff submitted an intelligence report after Mr Simpson and another prisoner exchanged threats. The other prisoner threatened to shoot Mr Simpson and to send people to Mr Simpson's mother's house. We found no evidence that these threats were investigated or that Mr Simpson was supported.

53. On 25 November, staff placed Mr Simpson on report for fighting with another prisoner. Staff submitted an intelligence report saying that there was no known reason for the fight but it was likely to be drug or debt related.

54. On 28 November, Mr Simpson was found to be under the influence of an illicit substance. Healthcare staff assessed him and staff submitted an intelligence report.

55. On 30 November, Mr Simpson assaulted an officer by throwing urine on her. Staff referred the incident to the police. An intelligence report suggested that Mr Simpson may have committed the assault in order to get moved from A Wing to the segregation unit due to debt issues. We found no evidence that this was investigated further. While in the segregation unit on 3 December, Mr Simpson told a prison GP that he was anxious and stressed. He asked for antidepressants and he prescribed sertraline.

56. Mr Simpson was moved from the segregation unit to H Wing on 5 December. He said he wanted support in relation to his substance misuse and he was allocated a substance misuse worker. Mr Simpson met with the substance misuse worker on 7 December and told her that he was using PS, cannabis and Subutex (a heroin substitute). He felt that his mental health was stable and told her he was taking antidepressants. She referred Mr Simpson to the Reduction and Motivation Programme (RAMP).

57. On 14 December, Mr Simpson was moved back to standard regime. He had been on basic regime since 6 October due to his behaviour.

58. On 3 January 2018, Mr Simpson met the substance misuse worker again. She noted that he had not been attending RAMP and he said he did not know he was meant to be on it. He admitted to daily use of Subutex, saying it was a cheap, available, coping mechanism as his prescribed medication was not working. He told her that he just wanted to be released from prison but she noted that he had just received 20 extra days on his sentence for failing a mandatory drug test and was awaiting further charges in relation to the assault on the prison officer.

59. On 8 January, a prison GP changed Mr Simpson's antidepressant medication from sertraline to citalopram at his request. Mr Simpson told the GP that he was still using Subutex but not PS and he asked for help.

60. On 15 January, Mr Simpson was moved to G Wing. Two days later, on 17 January, he told an officer that he felt suicidal and staff opened an ACCT. An

interim ACCT review was chaired by a SO on 18 January as no one from the mental health team was available to attend. He noted that Mr Simpson was feeling stressed because he had been moved to a cell that did not have a working television aerial. He said that Mr Simpson would be moved to another cell as soon as one became available.

61. On 19 January, Mr Simpson was moved back to H Wing. He had his second ACCT case review which was chaired by a SO and attended by a CPN. Mr Simpson said he had manipulated the system to get a move to a different wing. He said that he felt he was being punished when he was moved to G Wing into a cell with no working television aerial. Staff agreed to close the ACCT and a post-closure interview was scheduled for 26 January. Staff did not complete a caremap.

62. On 12 February, Mr Simpson told the substance misuse worker that he no longer wanted to work with the substance misuse team.

63. On 8 March, the psychiatric nurse was approached by an officer on H Wing who told him that Mr Simpson seemed more anxious than usual and that he had requested a review of his antidepressant medication. The nurse noted that Mr Simpson was no longer on the mental health caseload but he requested an appointment with the doctor to review his medication.

64. On 15 March, Mr Simpson was found to be under the influence of an illicit substance and an improvised bladed weapon was found in his cell. Three days later on 18 March, Mr Simpson was found to be under the influence again. Staff submitted intelligence reports and placed Mr Simpson on basic regime for 28 days.

65. Mr Simpson got into fights with different prisoners on 20 March, 1 April, 2 April, 5 April, 9 April and 20 April. During this time, Mr Simpson was moved to three different locations in the prison, eventually moving to D Wing on 11 April. Intelligence reports on 2, 9 and 20 April suggested that Mr Simpson was fighting with prisoners in exchange for PS or to repay drug debts. We found no evidence that these suspicions were investigated further. Mr Simpson remained on basic regime throughout this time.

66. On 2 May, at approximately 5.00am, an officer was carrying out the morning roll check. He could not see Mr Simpson when he looked through the cell door, so he turned on the light and saw him hanging from his bed by a sheet. He immediately used his radio to call for urgent assistance. Another officer responded immediately and they both went into Mr Simpson's cell. One officer held Mr Simpson's weight while the other officer cut the ligature. Both officers noted signs of rigor mortis so they did not attempt cardiopulmonary resuscitation (CPR). A nurse, the appointed first medical responder arrived shortly afterwards and agreed CPR was futile.

67. The incident log notes that an officer call for assistance was made at 5.03am and the control room called an ambulance at 5.05am. The paramedics arrived at 5.12am and Mr Simpson was pronounced dead at 5.20am.

Contact with Mr Simpson's family

68. Mr Simpson's mother was listed as his next of kin. Because of the distance to her home from Manchester, the prison asked staff from HMP Wakefield (which was nearer) to visit Mr Simpson's mother and break the news of her son's death. They did so at approximately 11.25am on 2 May. The prison contributed to the cost of Mr Simpson's funeral, in line with Prison Service instructions.

Support for prisoners and staff

69. Staff involved in the emergency response said that they were offered support by the prison's care team and felt supported by managers and other colleagues. However, we found no evidence that a debrief took place immediately after the incident.

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

Post-mortem report

71. The post-mortem report concluded that Mr Simpson's death was due to hanging. Toxicology results showed the presence of PS, but it was not possible to establish when the substances were taken or how they might have affected Mr Simpson at the time of his death.

Findings

Management of Mr Simpson's risk of suicide and self-harm

72. Prison Service Instruction (PSI) 64/2011, 'Safer Custody', says that ACCT case reviews should be multidisciplinary and reflect the prisoner's level of risk. The 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. The PSI includes a mandatory action for a post-closure review to be held within 7 days when an ACCT is closed. The post-closure interview must review the caremap and the progress made by the prisoner since the ACCT was closed.

73. We found that staff did not appropriately manage Mr Simpson's risk when he was monitored under ACCT procedures. After ACCT monitoring started for the first time on 22 June, staff did not assess Mr Simpson's risk and did not complete a caremap. The ACCT was closed on 26 June and reopened the next day after Mr Simpson set fire to his cell. Staff did not reassess his risk or complete a caremap. When the ACCT was closed on 12 July, there was still no caremap and no post-closure review.

74. ACCT monitoring started again on 17 January 2018 and Mr Simpson's risk was appropriately assessed as raised. The ACCT was closed two days later and a post-closure review was held but, again, there was no caremap.

75. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that they:

- **complete ACCT caremaps to include specific, meaningful and time bound actions, aimed at reducing prisoners' risks to themselves, consider progress at each review and update the caremaps if additional needs are identified;**

- **assess and record risk at each review, especially when an ACCT is reopened, and clearly document the reasons for any change in risk; and**

- **hold a post-closure review within seven days of closing an ACCT.**

76. There were signs in the couple of months before his death that Mr Simpson might be at a raised risk of suicide or self-harm: he asked for a review of his antidepressant medication; he was known to be using illicit drugs; there was intelligence that he might be assaulting other prisoners to pay drug debts; he was subject to frequent moves which made it difficult for staff to get to know him; and he was spending long periods in a single cell on a basic regime without a television. If he had seen a GP about his medication; if the intelligence had been investigated; if he had had the support of a personal officer or key worker; or if he had not been moved around the prison so much, it is possible that these signs might have been recognised.

77. None of this happened, however, and we do not consider that the wing staff who dealt with Mr Simpson in the weeks before his death could reasonably have been expected to be aware that his risk of suicide or self-harm had increased after the last ACCT was closed on 19 January. We make the following recommendation:

The Governor should ensure that all prisoners have a single named member of staff assigned to them who supports and encourages them to achieve their objectives.

Violence reduction

78. Although Mr Simpson was often investigated under the prison's Violence Reduction Strategy as a perpetrator of violence, we consider that Mr Simpson was also a victim at times due to being threatened because of drug debts. We found no evidence that Mr Simpson's allegations were investigated but, instead, he was frequently moved to different parts of the prison where the cycle of drugs, debt and violence would start again. We were also concerned to find that no one took action when it was suspected that Mr Simpson may have been carrying out violent incidents in exchange for illicit drugs or to repay drug debts. We make the following recommendation:

The Governor should ensure that all incidents of violence are investigated in accordance with PSI 64/2011 and Manchester's own Violence Reduction Policy, including providing feedback on the investigation to the victim and ensuring that details of the investigation are appropriately documented.

Managing challenging behaviour

79. Mr Simpson had complex needs, including a history of violence towards others, substance misuse and mental health issues. He also told staff that he was being threatened by other prisoners. He was in a cell on his own due to his high risk of harm to others and he was on the basic regime for long periods due to his behaviour. We found no evidence that he was engaging in any purposeful activity. Mr Simpson moved wings around 20 times during his 11 months in Manchester which made it very difficult for staff to engage with him. We consider that staff should have considered alternative methods of managing Mr Simpson's challenging behaviour and meeting his complex needs.

80. We are aware that the Safer Custody team at Manchester now holds weekly multidisciplinary meetings where prisoners with complex needs are discussed and plans put into place to manage their behaviour. We consider this to be an example of good practice and we therefore make no recommendation on this point.

Mental health

81. The clinical reviewer concluded that Mr Simpson's mental health care was not equivalent to that which he could have expected to receive in the community. While the care provided by mental health clinicians was of a good standard, there was a flaw in the system for allocating GP appointments. This meant that Mr Simpson had been waiting nearly two months to see a GP for a review of his mental health medication and he took his life before the date of the scheduled appointment on 9 May. A contributory factor in this delay was the fact that Mr

Simpson moved around the prison frequently, resulting in the GP appointment being rescheduled several times. We consider this was an unacceptable delay and we therefore make the following recommendation:

The Head of Healthcare should ensure that:

- **the appointment allocation system is robust and effective in facilitating GP interventions for patients subject to frequent cell movement around the prison; and**
- **prisoners have access to mental health services equivalent to those in the community.**

Emergency response

82. PSI 03/2013, 'Medical Emergency Response Codes', says that all staff must be made aware of and understand their responsibilities during medical emergencies. The PSI requires staff to radio a medical emergency code to communicate the nature of a medical emergency efficiently. The code triggers healthcare staff to take the relevant equipment to the scene, and control room staff to call an ambulance without delay.

83. When an officer found Mr Simpson hanging in his cell, he should have used a medical emergency code blue, which indicates that a prisoner is unconscious or having breathing difficulties. He did not do so and instead called for urgent assistance. Although we found there was no delay in the emergency response and it did not affect the eventual outcome for Mr Simpson, we are concerned that failure to use the correct emergency code could be significant in future incidents. We are also concerned that we have made similar recommendations following previous deaths at Manchester. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of the correct medical emergency codes and have appropriate training in the use of emergency call signs.

Staff support

84. PSI 64/2011 on Safer Custody says, "In line with PSI 08/2010 Post Incident Care, a 'Hot Debrief' must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. It may be useful to keep a record of those who attend." While staff said they felt supported by colleagues, managers and the prison's care team following the death of Mr Simpson, we found no evidence that a hot debrief was held immediately after the incident. We therefore make the following recommendation:

The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, that all those involved in the incident are invited to attend, and that an accurate written record of attendees is kept.

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