

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Akam, a prisoner at HMP Lindholme, on 13 October 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.

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 Daniel Akam was found hanged in his cell at HMP Lindholme on 13 October 2018. He was 43 years old. I offer my condolences to Mr Akam's family and friends.

Mr Akam was being monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) when he died. I am very concerned that on the morning he was found hanged, staff failed to check on him when they should have done. He was found hanged at 9.45am and was last checked at 8.45am, despite being on two checks an hour. This was not acceptable. We cannot say whether the failure to check on Mr Akam affected the outcome, but it may have done.

We identified a number of other deficiencies in the operation of ACCT procedures, which the prison needs to address.

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

January 2022

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Summary

Events

1. In July 2017, Mr Daniel Akam was remanded in custody, charged with burglary, and sent to HMP Hull. He was later sentenced to five years in prison. In May 2018, Mr Akam was moved to HMP Lindholme.
2. On 8 October, staff started suicide and self-harm prevention procedures (known as ACCT) after Mr Akam said that he was scared of being assaulted by other prisoners. The ACCT case manager arranged to move Mr Akam to a different wing.
3. Mr Akam made some superficial cuts to his wrists on the morning of 10 October. Staff held a case review later that day as scheduled. They set observations at two an hour. A nurse described him as extremely anxious and sent the prison psychiatrist an electronic request to prescribe anti-anxiety medication. (The request was not opened until after Mr Akam's death.)
4. An officer checked Mr Akam at 8.45am on 13 October but he failed to carry out the next check due around 30 minutes later. At 9.45am, another officer unlocked Mr Akam's cell and found him lying on his cell floor. When officers entered the cell, they found that Mr Akam had a ligature around his neck. Officers called a medical emergency code and began cardiopulmonary resuscitation (CPR). Nurses arrived to assist.
5. Paramedics arrived at 10.09am and assisted with CPR. Their efforts were unsuccessful and at 10.29am, the paramedics pronounced that Mr Akam had died.

Findings

6. On the morning of 13 October, no one checked on Mr Akam between 8.45am and 9.45am, although he was supposed to be checked twice in every hour. This was unacceptable, especially as an officer was seen on CCTV outside Mr Akam's cell at around 9.20am, who did not check on him. We cannot say whether the failure to check on Mr Akam affected the outcome, but it may have done.
7. We found several deficiencies in the management of ACCT procedures. Healthcare staff did not attend Mr Akam's first ACCT case review, which is a mandatory requirement, and when Mr Akam harmed himself on the morning of 10 October, staff failed to conduct an immediate reassessment of his risk.
8. Staff did not investigate Mr Akam's allegations of threats against him in line with the prison's violence reduction policy.
9. The clinical reviewer considered that, following the case review on 10 October, the nurse should have tasked a GP to prescribe anti-anxiety medication and not the prison psychiatrist.
10. The prison had difficulties in locating Mr Akam's next of kin because the address given by Mr Akam for his father was incorrect. When the prison made contact

with another family member who offered to contact Mr Akam's father, the prison accepted the offer and did not make direct contact. We consider that Lindholme should have made direct contact with Mr Akam's father.

Recommendations

- The Governor should provide the Ombudsman with a copy of the report of the disciplinary investigation into Officer B's failure to carry out the ACCT check, including the reasons why it was decided to take no further action.
- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance, including that:
 - healthcare staff attend all first case reviews;
 - staff review the level of risk and frequency of observations immediately if the prisoner's circumstances change, and do not wait for the next ACCT review;
 - staff hold multidisciplinary case reviews; and
 - staff adhere to the frequency of observations set out in the ACCT document and conduct observations at unpredictable times.
- The Governor should ensure that investigations into acts and threats of violence are conducted and completed in accordance with the prison's violence reduction policy.
- The Head of Healthcare should ensure that healthcare staff know the criteria for referring prisoners to GPs and prison psychiatrists to ensure that tasks are actioned promptly by the appropriate personnel.
- The Governor should ensure that following a death in custody direct contact is made with the nominated next of kin and or other immediate family members wherever possible, in line with Prison Service Instruction 64/2011.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Akam's prison and medical records. He interviewed 13 members of staff and one prisoner at Lindholme on 28 and 29 November 2018 and subsequently spoke to three other staff by telephone.
13. NHS England commissioned a clinical reviewer to review Mr Akam's clinical care at the prison. They jointly interviewed staff.
14. We informed HM Coroner for Doncaster of the investigation. The Coroner sent us the results of the post-mortem examinations. We have given the Coroner a copy of this report.
15. We separately contacted Mr Akam's partner, father and the mother of his child to explain the investigation process and to ask if they had any matters they wanted the investigation to consider. They did not raise any issues.

Background Information

HMP Lindholme

16. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Care UK provides healthcare services with healthcare staff on duty between 7.30am and 7.30pm every day.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Lindholme was in October 2017. Inspectors found some examples of good care for prisoners subject to ACCT, but found that the quality of care was mixed. Inspectors observed generally constructive and friendly interactions between staff and prisoners but they noted an influx of new staff and prisoners commented that the large number of new, less experienced officers had yet to develop the capacity to be as helpful as others. Inspectors noted that mental health provision was not meeting the high levels of need at Lindholme. They noted that chronic staffing shortages, particularly in primary mental health, and a lack of consistent clinical leadership had adversely affected provision.

Independent Monitoring Board

18. 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 31 January 2018, the IMB reported that there were indications that the prison was less safe than in the previous reporting year with increased levels of self-harm. The IMB found that ACCT procedures were operating effectively.

Previous deaths at HMP Lindholme

19. Mr Akam was the tenth prisoner to die at Lindholme since October 2016. Of the previous deaths, three were self-inflicted, four were drug related and one was from natural causes. There have been two deaths since, one self-inflicted and one awaiting classification.
20. In our investigation into a death in November 2017, we found there was poor ACCT management, including no healthcare attendance at case reviews, and a failure to carry out ACCT observations at the agreed frequency.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to

identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. On 19 July 2017, Mr Akam was arrested and remanded in prison custody charged with burglary. He was sent to HMP Hull. At the time of his arrest, Mr Akam was on bail charged with an earlier offence of false imprisonment.
23. On 19 February 2018, Mr Akam was convicted of both offences and on 20 February, he was sentenced to five years in prison.
24. On 11 May, Mr Akam was moved to HMP Lindholme. On arrival at Lindholme, Mr Akam told a reception nurse that he had never harmed himself and that he had no thoughts of suicide or self-harm. He also said that he had bipolar disorder. The reception nurse noted that Mr Akam was being prescribed methadone (heroin substitute) and 15mg of mirtazapine for depression. Later that day, Mr Akam told a safer custody officer that he was happy to be at Lindholme and that he did not have any problems with any of the prisoners there.
25. Following his induction, Mr Akam was moved to a cell on G Wing.
26. On 24 May, Mr Akam saw a nurse for a mental health assessment. She noted that while Mr Akam said that he was not having thoughts of self-harm, he felt generally hopeless. He said that while in the community he had threatened to jump off a building and was subsequently admitted to a psychiatric unit. Mr Akam accepted the nurse's offer of assistance with coping skills to help deal with his symptoms of low mood and anxiety and she planned to see him for a follow-up appointment to discuss further help.
27. Mr Akam had a follow-up review with the nurse on 20 June. Mr Akam said that he was still generally low in mood, although his mood fluctuated day to day. He said that he would never harm himself in custody as he did not want "the system to beat him". The nurse noted that Mr Akam's main anxiety appeared to be uncertainty about his release from custody and where he would live. The nurse advised Mr Akam to put his thoughts and feelings and potential solutions for his concerns on paper.
28. On 31 July, a prison GP doubled Mr Akam's mirtazapine dose from 15mg to 30mg per day due to his ongoing anxiety.
29. Mr Akam's next review with the nurse was on 7 August. Mr Akam said that he was still experiencing mood swings but was having fewer bad days and he believed that the increased dose of mirtazapine was helping. She noted that they discussed "distorted thinking" and how he could change negative thoughts into positive ones. She noted that Mr Akam had been given literature on positive self-affirmation and an anxiety diary to record his distorted thinking as it occurred. She noted that Mr Akam was having no thoughts of self-harm.
30. Mr Akam saw the nurse again on 24 September. She noted that Mr Akam was clean and well-kempt and that his mood was stable. Mr Akam said that he was doing quite well and that he was working and keeping himself busy.
31. On 1 October, a substance misuse practitioner saw Mr Akam. He told her that he was "doing fine", although he was disheartened at the lack of experience of a

lot of the young officers. Mr Akam said that he had been receiving methadone for a long time and that he would like to start reducing his daily dose at a very slow rate in advance of his release from prison in January 2020. He said that he wanted to be free of methadone by the time of his release.

32. On the evening of 4 October, Mr Akam passed a note to an officer to say that he did not feel safe on G Wing as rumours were circulating about his conviction and he asked to move to the segregation unit. The prison opened a violence reduction file to consider the possible threat.
33. On 8 October, Mr Akam told a Supervising Officer (SO) that while he was in the community he had been severely beaten and the perpetrator had been convicted and sent to prison. He said that the perpetrator had discovered that he was in Lindholme and he was in fear of being assaulted by the perpetrator's friends. The SO described Mr Akam as anxious and upset. He started ACCT procedures.
34. An officer carried out an ACCT assessment interview with Mr Akam at just after 3.00pm on 8 October. The officer's assessment record included that Mr Akam was having thoughts of self-harm and that he had "looked at a hook on his wall and wondered would it hurt". The officer also noted that Mr Akam said that he felt worthless and that at that moment, he wanted to be dead. The officer said that during the interview Mr Akam was very nervous, very agitated and chaotic: he would say one thing one minute and something else the next. He said that everyone on the wing was saying he was "a grass" and they were going to assault him, but when pressed to name individuals, he could not say who was threatening him. The officer said that a member of staff walked past at one stage and Mr Akam jumped as though he feared he was about to be assaulted.
35. The officer told the investigator that due to Mr Akam's presentation, he wondered whether he might be mentally unwell or under the influence of an illicit substance. He decided he needed help with his assessment, so he telephoned healthcare to ask for a mental health nurse to join him. He said that was the first time he had asked for such assistance with an interview during the many years he had worked as an ACCT assessor. The ACCT assessor said when the mental health nurse joined the interview Mr Akam quickly calmed down.
36. The mental health nurse told the investigator that the ACCT assessor said that he was concerned about Mr Akam's behaviour as he was acting oddly and was mumbling and incoherent. She said that she checked Mr Akam's medical records and saw that he was receiving support from the primary mental health team for anxiety and for cognitive therapy.
37. The mental health nurse told the investigator that while Mr Akam was a little withdrawn, he maintained eye contact with her and there were no signs of significant agitation. She asked Mr Akam about his difficulties that day and he explained that he was under threat from other prisoners. The mental health nurse said that Mr Akam spoke coherently and at a normal rate and volume and tone. She said that Mr Akam was rational, with no indication of confusion and he denied having thoughts of self-harm or suicide. The mental health nurse said that having had that conversation with Mr Akam, she was much happier professionally as Mr Akam was not incoherent as she had originally understood was the case.

38. The mental health nurse said that a SO arrived about ten minutes later and he took charge of the meeting to discuss Mr Akam's immediate safety needs. She said that she considered it was appropriate to leave the room at that point. She said that she had not been invited to attend an ACCT review, instead she had come to see Mr Akam very specifically due to the ACCT assessor's concerns that Mr Akam might be mentally ill.
39. The SO told the investigator that when he arrived, he read the ACCT assessment interview and then discussed with the ACCT assessor and Mr Akam the issues that led to the ACCT being opened. The SO said that Mr Akam appeared very anxious and seemed genuinely concerned that he was at risk. He asked to move to the segregation unit but the SO told him that would not be appropriate and he offered Mr Akam the option of moving to J Wing as soon as a cell was available. The SO said that Mr Akam agreed to that offer and his anxiety level seemed to drop. He asked Mr Akam if he intended to harm himself and he said he had no immediate thoughts of doing so.
40. The SO noted that the safer custody team would need to explore the possible threat against Mr Akam and that the mental health nurse would liaise with Mr Akam's keyworker. The SO noted that Mr Akam's next ACCT review would be on 10 October and that the mental health nurse should attend. The SO noted that he considered that Mr Akam was at low risk of self-harm and that he should be supported with one quality interaction every three hours. The SO completed a caremap with three action points: 1. Mr Akam should move to a new wing. 2. Mr Akam should receive support from his keyworker. 3. Transfer to a new prison should be considered depending on the investigation into the truth of the alleged threats. (In completing the record of the assessment, the SO indicated that the mental health nurse was a member of the ACCT review panel.)
41. Mr Akam was moved to J Wing at around 4.20pm on 8 October.

10 October

42. On the morning of 10 October, a nurse was called to see Mr Akam when staff noticed that he had cut his wrists and cut his face. The nurse noted that Mr Akam had inflicted superficial cuts to his wrists which she advised him to wash and she gave him dressings for him to self-apply. She noted that Mr Akam appeared agitated but he declined to discuss his concerns with her.
43. Mr Akam's ACCT case review was held at 11.00am as planned, around 90 minutes after he was seen by the nurse. No adjustment was made to his ACCT conversations and observations in the meantime.
44. The same SO chaired the second ACCT review. The other staff in attendance were a Custodial Manager (CM) and a mental health nurse (who attended in place of the original mental health nurse who was on sick leave that day). The SO said that he asked Mr Akam why he had harmed himself and he replied that he was frustrated that he was under threat. He said that a large mob of prisoners had gathered outside J Wing that morning to get to him and he made a comment along the lines that he "would be dead by tomorrow". The SO said that he understood by that, that Mr Akam meant that he would be killed by others by the following day, not that he would kill himself.

45. The SO told Mr Akam that he had already checked with his staff whether prisoners had congregated outside J Wing and his staff had assured him that it had been a normal morning with just the routine movement of prisoners going to work. He asked Mr Akam whether he really believed that a mob had gathered and Mr Akam replied “well, I thought they were there”. The SO told Mr Akam that they were going to investigate the potential threat and they would keep him safe. (the SO noted that he spoke to an officer from the safer custody team, who was going to carry out the investigation.) Mr Akam seemed to accept that reassurance, his anxiety level dropped, and he indicated that he would not harm himself again in the near future. The SO recorded that Mr Akam’s level of risk was raised. He increased support for Mr Akam to two observations per hour and three quality interactions per day.
46. The SO arranged the next ACCT case review for 12 October, which he would also chair, and he noted that a mental health worker should attend. (The mental health nurse noted this detail in Mr Akam’s medical record.)
47. The mental health nurse said that 10 October was her first time of meeting Mr Akam. She said that he presented as being quite low in mood and he said that he had had thoughts of suicide although that was not his immediate intention. She said she was content that two observations an hour was appropriate based upon the way Mr Akam had presented. When she returned to healthcare, she sent a ‘task’ (request for action) on the electronic medical records system to the prison psychiatrist, to ask him to prescribe short term anti-anxiety medication. (Mr Akam’s electronic medical record shows that the prison psychiatrist opened this task on 16 October.)
48. Mr Akam rang his cell bell at 10.15pm on the evening of 10 October and he told an operational support grade (OSG), that he feared he would be killed by other prisoners in the morning due to the rumours about his offence. The OSG told Mr Akam that his cell door would be kept locked to ensure his safety.
49. Another OSG carried out a number of night-time checks on Mr Akam. His entries indicate that Mr Akam was sometimes asleep and other times he was awake and watching television. The OSG noted at 3.30am on 12 October that Mr Akam rang his cell bell and asked to come out of his cell. He said that he told Mr Akam that he was being silly as he knew he could not come out of his cell at that time. He said that Mr Akam started to laugh and they had a brief chat. He said that there was nothing about Mr Akam’s demeanour to cause him concern and he thought that Mr Akam had just wanted some company.

12 October

50. On the morning of Friday 12 October, staff at Lindholme staged a protest over concerns for their safety after two officers were assaulted by prisoners the previous evening. Negotiations between management and the Prison Officers’ Association (POA) continued through much of the day and the prison operated with reduced staffing and with a reduced regime for prisoners.
51. When it became clear that there would not be an early resolution in the negotiations, staff from the regional safer custody team were summoned to Lindholme to carry out the ACCT case reviews scheduled for that day. Four staff

from the regional team arrived at Lindholme and during the afternoon they split into two teams to carry out the reviews. Lindholme's safer custody team printed a list of the prisoners with ACCT reviews scheduled for that day and with details of any specialist that should attend, such as mental health. The two teams checked the sheet and decided which team would review each of the prisoners.

52. Mr Akam's ACCT review was carried out by two CMs (the first team). The second team was originally due to review Mr Akam, but confusion arose when the first team were asked to help with another prisoner on J Wing with a similar name to Mr Akam. By the time the confusion was resolved, the first team told the second team that as they were already on J Wing, they would see Mr Akam.
53. Mr Akam's review started at 3.40pm. No one from the mental health team attended the review. Both CMs said that there was no indication on the sheet they had seen to say that a mental health nurse should attend, although one of the CMs said that the second team had telephoned a nurse for an oral contribution but she was engaged in a clinic at the time.
54. One of the CMs said that she read the record of Mr Akam's last ACCT review and checked the caremap action points. She said that she telephoned the mental health team, but there was no reply and a SO on duty on J Wing, was too busy to join them. The CM said that she and her colleague decided that they would need to do the review alone.
55. One of the CMs noted in Mr Akam's ACCT record that it was very difficult to ascertain Mr Akam's risk as he displayed very bizarre behaviour throughout the review. The CM told the investigator that Mr Akam's conversation was very stilted. She asked Mr Akam whether he intended to end his life and he shook his head to indicate "no". The CM said that she did not perceive that Mr Akam was at increased risk of self-harm but was instead more likely to pose a risk towards others.
56. The other CM gave similar evidence about the difficulty in trying to assess Mr Akam. She said that when he first came into the office he began talking as though he was speaking to someone standing outside the third-floor window. The CM said that Mr Akam did engage to an extent and spoke about his fixation in believing he was under threat from others. The CM made a note to say that Mr Akam's presentation "made it very difficult to ascertain [his] risk".
57. Both CMs decided that Mr Akam's observations should remain at two every hour with three quality interactions a day. They set his next ACCT review for Monday 15 October.
58. One of the CMs then telephoned the mental health team and was able to speak with the mental health nurse who had attended the second ACCT review. She told her that she considered Mr Akam's behaviour to be very bizarre and she asked what care he was receiving from the mental health team. The mental health nurse said that Mr Akam had been referred to the psychiatrist, but he would probably not be seen for some time. She asked if the CM wanted the psychiatric referral to be speeded up and the CM said that would be helpful. The CM added another action point to Mr Akam's caremap for a referral to mental

health and she noted: "... mental health spoken to. She has tasked the prison psychiatrist to see Daniel ASAP."

59. The mental health nurse told the investigator that she was the only mental health nurse on duty on 12 October and it had been an extremely busy day for her, which included issuing prisoners their medication. She said that she thought it was important she should attend Mr Akam's ACCT review and she made a number of telephone calls in the morning to find out when it was to be held. However, due to the lack of discipline staff she could not get any information.
60. The mental health nurse said that she then received a call in the afternoon from a CM in the regional team about Mr Akam's review. She told the CM that she was issuing medication at that time but would be back in the healthcare unit after about five minutes so could she call her back then with the time of Mr Akam's review. She said that she was not called back, and she later discovered that the review had been held without her. She said that she then received a call from the CM at just after 4.00pm asking her to confirm that the prison psychiatrist had been asked to review Mr Akam.

Events of 13 October

61. ACCT checks during the evening of 12 October recorded that Mr Akam spent most of his time watching television before falling asleep at about 11.00pm. Mr Akam was awake when he was checked at 5.00am on 13 October but subsequent checks found he was sometimes awake and sometimes asleep again.
62. Officer A checked Mr Akam at 7.35am. He said that Mr Akam was awake and he signalled that he was okay by giving a "thumbs up". He noticed that since he had last checked Mr Akam on the previous day, he had moved his locker from the side wall to the foot of his bed. He said that prisoners often rearrange their furniture and that is not a problem provided that officers can still see the prisoner through the observation panel in the cell door.
63. Officer A checked Mr Akam again at 8.01am. Mr Akam had fallen asleep since the previous check, but he responded when the officer kicked the door.
64. Officer B made an ACCT check at 8.45am and he noted that Mr Akam was lying on his bed. He told the investigator that he asked Mr Akam if he was okay and Mr Akam got out of bed and started walking to the door. Officer B told the investigator that it was not ideal trying to hold a conversation through a locked door so he told Mr Akam that he would be unlocking cells at 9.00am and would have a proper conversation with him then. He said that there was nothing about Mr Akam's presentation to cause him concern. That was the last time that Mr Akam was seen alive.
65. Mr Akam should have been checked again at around 9.15am. CCTV recording shows Officer B on the landing at around 9.21am. The recording shows that he looked at Mr Akam's cell door, but then walked away without looking into the cell. Officer B told the investigator that he was not entirely sure why he did not check Mr Akam, but he thought it was possible, as earlier, that he wanted to have a proper conversation with Mr Akam when the cell doors were unlocked.

66. CCTV footage shows a prisoner walking past Mr Akam's cell at around 9.40am. The prisoner told the investigator that as he passed the cell he heard a loud thump. He said that at the time he assumed the occupant had passed out after taking an overdose of Spice (a new psychoactive substance). He said that he had assisted prisoners in the past who had taken Spice but inhaling the fumes had damaged his own health and he no longer felt inclined to help.
67. Officer C was unlocking cells on Mr Akam's side of the landing that morning and he reached Mr Akam's cell at 9.45am. He told the investigator that when he looked through the observation panel, he saw Mr Akam lying on his side on the floor at the back of the cell and with his head directly below the cell window.
68. Officer C said that his initial thought was that Mr Akam might have been under the influence of an illicit substance as that was the main reason for prisoners being found lying on cell floors. He said that he shouted for staff support and called Mr Akam's name. Mr Akam did not respond so the officer radioed a medical emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties).
69. Officer B arrived within a few seconds and he unlocked the cell door. The officers went into the cell and rolled Mr Akam onto his back. Officer B then saw that Mr Akam had a tight ligature around his neck which he cut away with his anti-ligature knife. Mr Akam was not breathing so Officer B began giving chest compressions. Other officers arrived, as did several nurses. Officers took turns in giving chest compressions and the nurses checked Mr Akam with a defibrillator and gave him oxygen.
70. Ambulance paramedics were called when the code blue call was made and they arrived at Mr Akam's cell at 10.09am. The paramedics assisted with efforts to resuscitate Mr Akam. Efforts continued until 10.29am when the paramedics declared that further efforts should cease as Mr Akam was dead.

Contact with Mr Akam's family

71. Mr Akam had named his partner as his next of kin. A family liaison officer (FLO) and the Governor visited Mr Akam's partner's address, but they found that it was an unoccupied rental property. The FLO rang Mr Akam's partner's telephone, but it was disconnected. The staff then attempted to drive to an address in Hull listed for Mr Akam's father, but they found there was no such address. The FLO contacted Lindholme who told her of another address in Hull that might have been the home of Mr Akam's aunt. The staff drove to that address, but no one was at home. The staff then returned to Lindholme.
72. On return to Lindholme, the FLO discovered an address in Newcastle that might have been the address of Mr Akam's brother. The police agreed to pursue that line of enquiry, but nothing arose from those enquiries.
73. During the following days Lindholme attempted to obtain further information about Mr Akam's community ties, but they discovered he had made no telephone calls from the prison PIN phone system and that the only letters he had received were from his partner who listed her address as the empty property that had

already been visited. Enquiries with Mr Akam's offender manager gave the same non-existent address for Mr Akam's father.

74. On 17 October, Mr Akam's offender manager was able to provide an address in Hull for a previous partner of Mr Akam, the mother of his son. The FLO and Governor visited the ex-partner and were able to break the news to her of Mr Akam's death. The ex-partner asked if Mr Akam's father had been informed and when the FLO told her that they did not have a correct address for him, the ex-partner said that she would break the news.
75. On 23 October, Mr Akam's father's partner contacted Lindholme to ask why they had received no contact from Lindholme about Mr Akam's death.
76. Lindholme contributed to the cost of Mr Akam's funeral in line with national instructions.

Support for prisoners and staff

77. The Governor debriefed the staff who were involved in the response when Mr Akam was found. The staff care team also offered support. One SO said that he attended the debrief and was subsequently referred to occupational health for support, but he was still waiting to be contacted by them.
78. The prison posted notices informing other prisoners of Mr Akam'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 Akam's death.

Post mortem report

79. Mr Akam's post-mortem report gave his cause of death as hanging. Results of toxicology tests showed methadone and mirtazapine at therapeutic levels.

Findings

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

ACCT observations

80. Officer B was the last person to see Mr Akam alive, when he carried out an ACCT check at 8.45am. Mr Akam wanted to speak to him but Officer B told him that he would be unlocking cells at 9.00am and would speak to him then. In fact, staff did not start unlocking cells until much later that morning, because of the disruption caused by the industrial action the day before. Officer B did not speak to Mr Akam at 9.00am, or carry out the ACCT check due at around 9.15am.
81. CCTV footage shows Officer B by Mr Akam's cell at around 9.20am, but he did not check on him. When interviewed, Officer B said that he had decided to wait to speak to Mr Akam once his cell was unlocked so they could have a proper conversation through an open door. We do not accept this as a reasonable explanation for why the ACCT check was not carried out, especially as Officer B was so close to his cell.
82. Mr Akam was not checked again until 9.45am when his cell was unlocked by Officer C and he was found unresponsive on his cell floor. Staff and paramedics were unable to resuscitate him. We do not know what time Mr Akam hanged himself, but Officer B's decision not to carry out the ACCT check due at around 9.15am was a significant omission. We cannot say whether the failure to carry out the check affected the outcome for Mr Akam, but it may have done.
83. The prison suspended the Officer B from duty while they carried out an investigation under PSI 06/10, *Conduct and Discipline*. The investigation concluded that no action was necessary and Officer B returned to work.
84. We consider that Officer B's failure to carry out the ACCT check was unacceptable and we would have recommended that a disciplinary investigation be carried out. As the prison has already carried out an investigation, we make the following recommendation:

The Governor should provide the Ombudsman with a copy of the report of the disciplinary investigation into Officer B's failure to carry out the ACCT check, including the reasons why it was decided to take no further action.

Management of ACCT procedures

85. Staff started ACCT procedures for Mr Akam on 8 October when he reported that he was in fear of being assaulted by other prisoners. His assessment interview and first ACCT case review were held later the same day. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, says that it is a mandatory action for healthcare staff to attend the first case review. The SO who chaired the case review recorded that a mental health nurse attended the review. However, she told us that she had only gone to see Mr Akam because the ACCT assessor was concerned about Mr Akam's mental health (this is also what the ACCT assessor told us). The mental health nurse

said that she was not present as a member of the review team and that she left the review soon after the SO arrived.

86. It is clear that there was a breakdown in communication between the three staff about the first mental health nurse's participation. Once the SO had recorded that the mental health nurse was a participant, we are unclear why he did not question why she appeared to be leaving the review before its conclusion.
87. The SO said that Mr Akam's anxiety reduced when he was told he would be moved to J Wing and he set support at one quality interaction every three hours.
88. Mr Akam's next ACCT case review was set for 10 October. However, earlier that morning staff called a nurse as Mr Akam had made cuts to both wrists and to his face and he needed treatment. At that time, Mr Akam was being supported through one quality interaction every three hours. After being treated for his injuries by the nurse at 9.35am, no further entry was made in Mr Akam's ACCT document until his case review at 11.00am. No consideration appears to have been given in the meantime as to whether Mr Akam's level of risk might have increased and whether he should be observed pending the ACCT review. We consider that such a review should have been made.
89. The SO chaired the ACCT review on 10 October and he set observations at two an hour with three quality interactions a day.
90. The SO scheduled Mr Akam's next ACCT review for Friday 12 October, which he again intended to chair. However, the SO, who was also a POA official, was involved in the negotiations with management about the industrial action on 12 October. When it became clear there would not be a swift resolution, staff from the regional safer custody office were called into Lindholme to conduct ACCT case reviews that day.
91. Mr Akam's case review was conducted in the late afternoon by two CMs from the regional team. A mental health nurse had expected to attend the review but she was the only mental health nurse on duty which contributed to difficulty in communicating the time of the review. When the two CMs proceeded with the review alone, both noted that Mr Akam appeared distant, distracted and confused. They both recognised that Mr Akam needed assistance with his mental health and when they concluded the review they were able to speak to the mental health nurse by telephone. She told them that Mr Akam had been referred to the prison psychiatrist. Both CMs maintained Mr Akam's observations at two an hour and set his next review for the following Monday (15 October).
92. We are concerned that although the CMs from the regional team had concerns about Mr Akam's mental health, the ACCT review was not multidisciplinary. While we appreciate that the circumstances on 12 October were very unusual, we consider that more care should have been taken by the regional team to ensure that the mental health nurse could attend Mr Akam's ACCT review. For instance, the Head of Healthcare could have been asked to assist with the arrangements.
93. We also note that while a number of Mr Akam's ACCT observations were conducted at unpredictable times, the majority were not and were instead carried

out on the hour and half hour. PSI 64/2011 makes clear that observations must be made at unpredictable times.

94. We make the following recommendation:

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

- **healthcare staff attend all first case reviews;**
- **staff review the level of risk and frequency of observations immediately if the prisoner's circumstances change, and not wait for the next ACCT review;**
- **staff hold multidisciplinary case reviews; and**
- **staff adhere to the frequency of observations set out in the ACCT document and conduct observations at unpredictable times.**

Violence reduction

95. On 4 October, Mr Akam reported that he felt unsafe because he was under threat from other prisoners on G Wing. Staff opened a file that day in line with the prison's violence reduction policy. The policy requires that an investigation into incidents of violence and threats of violence should be completed within 72 hours of the report.

96. On 8 October, the ACCT assessor noted in the paperwork that Mr Akam's move to J Wing had relieved some of his stress. That was the final entry in the paperwork and another officer, who it appears was allocated the investigation, had no recollection of speaking to Mr Akam. The safer custody team told the investigator that staffing issues and competing priorities meant that they often struggled to complete violence reduction investigations within the 72 hour target. We make the following recommendation:

The Governor should ensure that investigations into acts and threats of violence are conducted and completed in accordance with the prison's violence reduction policy.

Clinical care

97. The clinical reviewer found that Mr Akam's overall care was of an acceptable standard and equivalent to that which he could have expected to receive in the community. She concluded that the mental health team engaged with Mr Akam in a timely and responsive way.

98. However, the clinical reviewer had some concerns about the action taken by the second mental health nurse following the ACCT case review on 10 October. Following the ACCT review, at which Mr Akam presented as extremely anxious and the second mental health nurse recorded that he needed something to 'settle him', she sent a 'task' to the psychiatrist to prescribe short term medication for anxiety. The psychiatrist did not open this task until 16 October, after Mr

Akam's death. The clinical reviewer considered that the second mental health nurse should have tasked this to a prison GP rather than the psychiatrist as prison GPs have sessions each day whereas the psychiatrist does not. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff know the criteria for referring cases to GPs and prison psychiatrists to ensure that tasks are actioned promptly by the appropriate personnel.

Contact with Mr Akam's family

99. PSI 64/2011 says, "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death."
100. Following Mr Akam's death, staff attempted to break the news to his partner in Hull but they found the home was an empty rental property and the telephone disconnected. When the staff then attempted to visit Mr Akam's father, they found the address given by Mr Akam did not exist (Mr Akam had made an error with the address).
101. Lindholme eventually obtained the address of Mr Akam's ex-partner and on 17 October they were able to inform her of the news. When she offered to notify Mr Akam's father of the news, Lindholme accepted her offer.
102. While we acknowledge the initial difficulties in locating Mr Akam's next of kin and other family members, we do not consider that Lindholme should have accepted Mr Akam's ex-partner's offer to notify Mr Akam's father. We consider that Lindholme should have obtained the correct address from the ex-partner and then visited Mr Akam's father to break the news to him directly.

The Governor should ensure that following a death in custody direct contact is made with the nominated next of kin or other immediate family members wherever possible, in line with PSI 64/2011.

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