

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

**Independent investigation into  
the death of Mr Dylan Archibald,  
a prisoner at HMP Hull,  
on 16 September 2018**

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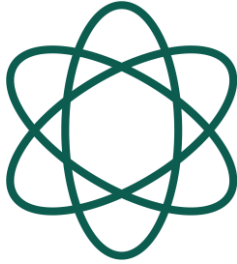
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## Our vision

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



## Our values

**We are:**

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**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity

**OGI**

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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.

I carry out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Dylan Archibald was found hanged in his cell at HMP Hull on 16 September 2018. He was 47 years old. I offer my condolences to Mr Archibald's family and friends.

We suspended our investigation for over a year while a police investigation into the circumstances of Mr Archibald's death took place. In May 2020, the Crown Prosecution Service informed us that they had decided not to proceed with a criminal prosecution. This unfortunately delayed our investigation and the production of this report.

The Crown Prosecution Service then reconsidered whether to proceed with a criminal prosecution, following an appeal by Mr Archibald's family. In October 2021, they informed us that they had concluded that there were no grounds to proceed with a prosecution. Unfortunately, this delayed the production of our final report.

Nine days before his death, Mr Archibald returned to HMP Hull after spending over three months as an inpatient at a secure psychiatric hospital. I am concerned that his risk of suicide and self-harm was not properly assessed on his arrival at Hull.

I am also concerned that the decision to move him from a healthcare setting to a standard residential unit four days after his arrival was premature and should have been made by a multidisciplinary team to ensure that all risks were considered and addressed.

A night patrol officer failed to make an important check around an hour before Mr Archibald was found hanged in his cell. It is not possible to say if this affected the outcome for Mr Archibald, but it may have done.

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

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

**November 2021**

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# Summary

## Events

1. On 15 November 2017, Mr Dylan Archibald was remanded in custody to HMP Lincoln. He had previously been diagnosed with drug-induced psychosis and, earlier that year, had been detained under the Mental Health Act. On 15 December, Mr Archibald was transferred to HMP Hull.
2. In early 2018, prison staff started suicide and self-harm prevention procedures (known as ACCT) on three occasions as Mr Archibald had harmed himself. During the year, Mr Archibald's mental health appeared to deteriorate, with symptoms including paranoia and erratic, unpredictable behaviour. On 22 May, he was transferred under the Mental Health Act to the Humber Centre, a medium secure psychiatric hospital.
3. On 7 September, Mr Archibald was discharged from the Humber Centre and was sentenced to 28 months in custody. He returned to Hull that day and was placed in the Wellbeing Unit (a small unit for prisoners who require continual support from healthcare staff). Prison staff assessed Mr Archibald's risk of suicide and self-harm on his first night in custody but some important aspects of the assessment, such as a management quality assurance check, were not completed.
4. On 10 September, a mental health nurse assessed Mr Archibald and concluded that he showed no evidence of the symptoms that led to his hospital admission. He recommended that Mr Archibald could live on a standard residential wing and, with the agreement of prison staff, Mr Archibald was moved to C Wing that day.
5. On the night of 15-16 September, the night patrol officer did not complete an early morning count of prisoners, as required. At 6.32am, an officer completing the next scheduled count found Mr Archibald hanged from a ligature. He requested support and, with colleagues, opened the cell, removed the ligature and began cardiopulmonary resuscitation (CPR). A prison nurse arrived shortly afterwards and asked the officers to stop CPR as it was apparent that Mr Archibald had died.

## Findings

### Identifying the risk of suicide and self-harm

6. Staff who assessed Mr Archibald's risk of suicide and self-harm when he returned to Hull did not accurately consider all his risk factors and did not complete all the required stages to ensure that his risk was fully assessed. As a result, we do not consider that Mr Archibald's risk was appropriately assessed. This is a particular concern as Mr Archibald had just been sentenced and transferred from a secure psychiatric hospital.
7. There is little evidence that staff had any meaningful individual contact with Mr Archibald after he moved to C Wing, and this reduced their chances of identifying any potential issues or any new risk factors for suicide and self-harm.

## **Clinical care**

8. The decision to move Mr Archibald out of the Wellbeing Unit and on to a standard wing was premature and should have been made in a multidisciplinary forum.

## **Roll checks**

9. The night patrol officer did not complete the required early morning roll check. While we cannot be certain, it is possible that the outcome might have been different if the check had been properly completed.

## **Recommendations**

- The Governor should ensure that staff consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm and start ACCT procedures when necessary.
- The Governor should ensure that officers have meaningful contact with prisoners, including individual conversations that allow them to get to know prisoners and identify their needs.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact him.
11. The investigator visited Hull on 20 September 2018. He obtained copies of relevant extracts from Mr Archibald's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Archibald's clinical care at the prison.
13. The investigator interviewed four members of staff at Hull in October and November, and the clinical reviewer interviewed two additional members of staff.
14. We informed HM Coroner for West Yorkshire Eastern District of the investigation. He gave us the results of the post-mortem examination and toxicology results and we have sent him a copy of this report.
15. In December 2018, we suspended our investigation while Humberside Police investigated the circumstances of Mr Archibald's death. On 7 May 2020, the Crown Prosecution Service told us that they had decided not to proceed with a criminal prosecution. We subsequently restarted our investigation. Although this was outside our control, we regret that the delay to the publication of this report.
16. The investigator contacted Mr Archibald's mother to explain the investigation. Mr Archibald's mother asked why Mr Archibald was moved from the Wellbeing Unit to a standard residential wing, why he had an electric head shaver, and how he sustained the broken ribs identified in the post-mortem examination. We have addressed these issues in this report.
17. We shared the initial report with HM Prison and Probation Service (HMPPS). They identified some factual inaccuracies which we have amended in this report.
18. We also shared the initial report with Mr Archibald's mother. She asked some questions which we have answered in separate correspondence.

## **Background Information**

### **HMP Hull**

19. HMP Hull is a local prison holding a maximum of 1,056 men on remand, convicted or sentenced. The prison serves the courts of Hull, Grimsby and York. City Health Care Community Partnership provides health services, including mental health services. The prison has 24-hour primary healthcare cover.

### **HM Inspectorate of Prisons**

20. HM Inspectorate of Prisons (HMIP) carried out an inspection of Hull in March 2018. Inspectors found reception procedures properly assessed presenting risk and induction arrangements were adequate. Hull had many experienced staff but also a significant tranche of newer staff, all of whom received good mentoring and support. Inspectors reported that prisoners with the greatest mental health needs were supported well, but the range of interventions and staffing resources did not meet all low-level needs.

### **Independent Monitoring Board**

21. 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 most recent report, for the year ending February 2019, the IMB reported that the Governor had set a high priority on reducing levels of self-harm. They found that there was a five per cent increase in the number of ACCT documents started compared to the previous reporting year.

### **Previous deaths at HMP Hull**

22. Mr Archibald was the eleventh prisoner to die at Hull since September 2016, and the third to take his own life. In the previous self-inflicted deaths, we made recommendations about the assessment of risk.
23. There have been ten deaths since Mr Archibald's, including five self-inflicted deaths. In the two self-inflicted deaths we have so far investigated, we have identified concerns about risk assessment.

### **Assessment, Care in Custody and Teamwork (ACCT)**

24. 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.

25. 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.

## Key Events

26. Mr Dylan Archibald had served a number of prison sentences and had most recently been released from custody in November 2010. He had a history of heavy alcohol and illicit drug use. He had cirrhosis of the liver, chronic hepatic encephalopathy (changes to the brain caused by liver disease and giving rise to confusion, anxiety and personality changes) and oesophageal varices (enlarged veins in the oesophagus associated with liver disease). He had also had several episodes of drug-induced psychosis.
27. In August 2017, Mr Archibald was detained under the Mental Health Act after he presented as paranoid and agitated. After his release, he did not attend any follow-up appointments in the community.
28. In November 2017, Mr Archibald was remanded to prison charged with arson with intent to endanger life. In December he was transferred to HMP Hull.
29. Between January and March 2018, Mr Archibald was managed under suicide and self-harm prevention procedures (known as ACCT) on three occasions. Staff recorded that his behaviour was “erratic and unpredictable” and that he became increasingly anxious and paranoid, urinated in his cell, and at times “talked gibberish” and thought there were people in his cell.
30. In April, a psychiatrist at the Humber Centre, a medium secure psychiatric hospital, assessed Mr Archibald. He concluded that Mr Archibald had several diagnoses, including paranoid schizophrenia (a long-term mental health condition, symptoms of which include hallucinations and delusions) and drug-induced psychosis. He recommended that Mr Archibald should be urgently transferred to a secure hospital for further assessment.
31. On 22 May, Mr Archibald was transferred to the Humber Centre under the Mental Health Act. He was prescribed haloperidol (antipsychotic medication). His mental health stabilised and, after his haloperidol prescription was stopped in early July, Mr Archibald had no further reported symptoms of psychosis.
32. A senior mental health nurse at Hull told the clinical reviewer that Hull began planning for Mr Archibald’s potential return to prison in August. They were unable to attend a planning meeting at the Humber Centre on 19 August and no further meeting was arranged.
33. On 4 September, staff at the Humber Centre emailed the senior mental health nurse with a discharge plan before Mr Archibald’s forthcoming court appearance. The plan recommended that Mr Archibald should be admitted to the Drug Recovery Wing (A Wing) and should engage with substance misuse services if he returned to Hull.

## HMP Hull

34. On Friday 7 September 2018, Mr Archibald was discharged from the Humber Centre to appear at Hull Crown Court. A consultant forensic psychiatrist at the Humber Centre provided a full discharge summary. She confirmed Mr Archibald

had cirrhosis of the liver, chronic hepatic encephalopathy, oesophageal varices and drug-induced psychosis. He was prescribed lansoprazole (to reduce gastric acid), ranitidine (for gastric reflux), rifamixin (for hepatic encephalopathy), furosemide (for water retention), thiamine (vitamin B1) and lactulose (for constipation and hepatic encephalopathy). She advised that Mr Archibald should receive ongoing mental health support.

35. At court, Mr Archibald was convicted of arson and was sentenced to 28 months in prison. He was due for release in January 2019. He was sent to Hull.
36. A nurse assessed Mr Archibald when he arrived at Hull. He recorded that Mr Archibald had been discharged from the Humber Centre and that the mental health team were aware that he had returned to Hull. He also recorded the medication that the forensic psychiatrist prescribed, and that Mr Archibald should collect this every day rather than keep it in his cell. Mr Archibald refused to be referred to the substance misuse team. He recorded that Mr Archibald said that he had not sustained any physical injuries recently.
37. The nurse recorded that Mr Archibald told him that he had not harmed himself in the last year (which was not correct) and that he had no current thoughts of harming himself. He recorded that there were “mild concerns” that Mr Archibald might harm himself.
38. The Drug Recovery Wing was full, so Mr Archibald was allocated a cell on the Wellbeing Unit until the mental health team could assess him.
39. An unknown officer then completed a first night assessment. (The officer did not print their name on the relevant part of the assessment form.) The officer incorrectly recorded that Mr Archibald had no history of self-harm in custody and noted that he said he had no current thoughts or plans of suicide or self-harm.
40. The first night assessment form contains a free text box in which the assessor is required to record what factors they have considered about the prisoner’s risk of harming themselves and the reasons for deciding whether or not to start ACCT procedures. It includes the instruction that if staff are in any doubt, they must start ACCT procedures. The officer is required to copy their record to the prisoner’s electronic prison record (NOMIS case notes). The first night officer did not complete this box or record any risk information in Mr Archibald’s case notes. The form also included a section for a manager’s quality assurance check which was not completed.
41. Mr Archibald brought a set of electric hair clippers to Hull with him from hospital. In line with local policy, he was permitted to keep these in his cell.
42. On 8 September, an officer recorded that Mr Archibald had been “a pleasure” and that he had engaged well with staff and fellow prisoners.
43. On 9 September, an officer recorded that Mr Archibald had been quiet and said he was “okay” when asked.
44. On 10 September, a mental health nurse assessed Mr Archibald. He had been Mr Archibald’s care coordinator at Hull before he transferred to the Humber Centre in

May and he knew him well. He recorded that Mr Archibald appeared in good spirits and that he said that he felt a lot better and had fewer paranoid thoughts.

45. The nurse told the clinical reviewer that Mr Archibald showed no evidence of the symptoms he had displayed before he was transferred to the Humber Centre, and that he had no obvious mental health issues. He concluded that Mr Archibald was at low risk of suicide. He told the clinical reviewer that there was no reason for Mr Archibald to remain in the Wellbeing Unit, and he recorded that Mr Archibald said that he was happy to move to a standard residential wing. He booked a follow-up appointment with Mr Archibald for 14 September.
46. Prison staff agreed that Mr Archibald could leave the Wellbeing Unit. He moved to C Wing later that day.
47. On 12 September, an officer recorded that Mr Archibald had refused to attend the Resettlement Centre for a learning and skills assessment. She issued him with a warning under the prison's Incentives and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible behaviour in prisons). This was the only entry made by a member of staff following Mr Archibald's move to C Wing that indicated that they had spoken to him.

## **16 September 2018**

48. At 5.25am, an operational support grade (OSG), who was the night patrol officer on C Wing, recorded that she had conducted the early morning roll check (a count of prisoners to ensure that all are present). In a statement following Mr Archibald's death, she wrote that she used her torch to look into his cell and that he appeared to be asleep. The night patrol officer gave a similar account to Humberside Police. However, CCTV footage showed that she did not go to Mr Archibald's cell, and she told us that her statement was incorrect and that she had not completed the roll check as required.
49. At 6.32am, an officer conducted a roll check at the start of his shift. He looked through the observation panel in Mr Archibald's door and saw him hanged from a ligature made from the cord of his electric hair clippers. He radioed a medical emergency code blue immediately, indicating that a prisoner is unable to breathe or having difficulty breathing. The control room operator telephoned for an ambulance.
50. A Custodial Manager (CM) went to the cell immediately and he and the officer entered the cell. They cut the ligature and began cardiopulmonary resuscitation (CPR).
51. At around 6.35am, a nurse arrived and immediately told the staff to stop CPR. She told the investigator there were clear signs of blood pooling which indicated that Mr Archibald had been dead for some time. Paramedics arrived shortly afterwards and confirmed that Mr Archibald had died.

## **Contact with Mr Archibald's family**

52. Prison family liaison officers visited Mr Archibald's mother that morning and told her of his death. Hull contributed to the costs of the funeral in line with Prison Service instructions.

## **Support for prisoners and staff**

53. The Head of Reducing Reoffending debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
54. The prison posted notices informing staff and prisoners of Mr Archibald'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 Archibald's death.

## **Post-mortem report**

55. A post-mortem examination identified that the cause of Mr Archibald's death was hanging.
56. Toxicology tests found that Mr Archibald did not have any illicit substances in his system when he died. He did have several of the medications he had been prescribed in his system, but the pathologist said that these would not have contributed to his death in any way.
57. The pathologist noted that Mr Archibald had no injuries on his neck or elsewhere that might suggest he had been subject to a recent physical assault.
58. However, the post-mortem found that Mr Archibald had three healing rib fractures in the middle of his back on the left side. The pathologist noted that these were well established and probably at least several weeks old. He said that they would have been due to the application of blunt force and a heavy impact and that they could potentially have been caused by a historical heavy fall or an assault.
59. Mr Archibald had only been back at Hull for nine days before he died and before that he had been at the Humber Centre for more than three months, from 22 May to 7 September. It seems likely, therefore, that Mr Archibald had sustained his rib fractures while he was at the Humber Centre. We have not been able to investigate this as detention in secure psychiatric hospitals is not within the PPO's remit.

# Findings

## Identifying the risk of suicide and self-harm

60. 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 Hull should have recognised Mr Archibald as at risk and begun ACCT procedures to support him.
61. Mr Archibald had some very significant risk factors for suicide and self-harm. He had harmed himself in prison earlier in the year, he had a mental ill health diagnosis and had just been discharged from a psychiatric hospital. He also had substance misuse issues and was recently sentenced and newly arrived at Hull.
62. Given this, we would have expected staff to have paid particular attention to Mr Archibald's risk assessment. However, we are not satisfied that Mr Archibald's risk factors were properly assessed when he arrived at Hull. The first night assessment incorrectly stated that Mr Archibald had no history of self-harm in custody (even though this information is readily available on the electronic prison record) and the consideration of all risk factors and reasons whether to start ACCT procedures was not completed. The management assurance check was also incomplete.
63. These failings would have been a concern in any case but are a particular concern in the case of a man who had just been sentenced and transferred from a secure psychiatric hospital. Whether or not Mr Archibald was managed under ACCT procedures, we think that arrangements should have been put in place to monitor him until staff were sure that he had settled at Hull. His consultant psychiatrist at the Humber Centre had clearly envisaged this when she recommended that he initially be located in the Drug Recovery Unit when he returned to Hull.
64. We are also concerned that there is little evidence that staff had any meaningful conversation with him during his nine days at Hull, especially after his move to C Wing on 10 September 2018. Staff engagement is particularly important in the first weeks in custody and without such contact, it is more difficult for staff to identify whether a prisoner has any issues or might be more vulnerable to suicide and self-harm.
65. As Mr Archibald was not being managed under ACCT procedures and as staff apparently had very little contact with him, it is very difficult to say whether Mr Archibald may have given any indication that he was at immediate risk of suicide or self-harm in the days before his death. All we can say is that staff did not record any concerns about him.
66. We make the following recommendations:

**The Governor should ensure that staff consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm and start ACCT procedures when necessary.**

**The Governor should ensure that officers have meaningful contact with prisoners during their first weeks in custody, including individual conversations that allow them to get to know prisoners and identify their needs.**

## **Clinical care**

67. The clinical reviewer noted that after Mr Archibald was discharged from the Humber Centre, there was a requirement, under section 117 of the Mental Health Act 1983, for him to be followed up by a mental health professional within seven days. A nurse assessed Mr Archibald on 10 September, three days after his discharge, and this requirement was therefore met.
68. The nurse concluded that Mr Archibald did not show any signs of the symptoms that had led to his admission to the Humber Centre. He recommended that it was appropriate for Mr Archibald to live on a standard residential unit, rather than the Wellbeing Unit.
69. The clinical reviewer concluded that this decision was premature, given how recently Mr Archibald had returned from the psychiatric hospital where he had been detained under the Mental Health Act. The clinical reviewer's view was that the decision to move Mr Archibald to a standard wing should have been made through a multi-disciplinary forum to ensure that all risks had been fully assessed and mitigated against. We agree and we note that Mr Archibald's consultant psychiatrist at the Humber Centre had clearly not envisaged that he would be placed on a standard wing with no additional support only four days after his discharge from hospital.
70. Since Mr Archibald's death, the Governor and Head of Healthcare have issued new Wellbeing Unit referral criteria. These include the requirement that a multidisciplinary team produce a reintegration plan as part of the discharge process when a prisoner leaves the unit. The clinical reviewer was satisfied that this is in line with section 117 of the Mental Health Act. We do not therefore make a recommendation.

## **Hair clippers**

71. Mr Archibald used the cable from his electric hair clippers to hang himself and his mother has asked why he was allowed to have such an item in his possession.
72. We know from our investigations that prisoners use a very wide variety of materials to make ligatures to hang themselves, including bedding and their own clothes. In our experience a prisoner who wants to kill themselves will use anything they have to hand. The only way to be certain that a prisoner has no access to anything he could use to kill himself is to place him in a completely bare cell with no furniture or possessions (known as special accommodation) in special rip-proof clothing, or to place him in a body belt. This obviously has an adverse effect on mental health and the use of special accommodation or body belts are therefore exceptional measures that have to be specially authorised and monitored. In Mr Archibald's case, staff had concluded that he was not at risk of suicide or self-harm and the use of such extreme measures was not therefore considered and would not have been justified.

73. Although we understand Mr Archibald's mother's concern, we do not think that allowing Mr Archibald to have his clippers in his possession was the key issue. If he had not used the cord, he would almost certainly have used something else if he was determined to kill himself. The key issue is that his risk of suicide was not identified, and no measures were put in place to support him and reduce his risk.

## **Roll checks**

74. The purpose of a roll check is to ensure that all prisoners are accounted for, but staff are also expected to take action if they have any concerns about a prisoner's safety or welfare when conducting a roll check.
75. The night patrol officer did not conduct the roll check on the morning of 16 September 2018, as she was required to do. She told both the Governor and the police that she had completed the check, but CCTV footage showed that she had not. While we cannot be sure whether proper completion of this roll check would have affected the eventual outcome for Mr Archibald, it is possible that it may have done.
76. The night patrol officer's actions have been subject to a criminal investigation by Humberside Police (which did not result in any criminal charges) and internal Prison Service disciplinary procedures. The internal investigation resulted in her employment being terminated. However, her employment was reinstated on appeal.
77. On 15 November 2018, the Governor issued a notice to staff setting out the requirement for effective roll checks and prisoner welfare checks to be conducted at night. The notice stated that ongoing random sampling of wing-based CCTV would be undertaken to ensure such checks were taking place. We do not therefore make a recommendation.

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