

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Daniel Warwick, a prisoner at HMP Hull, on 5 November 2019

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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

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.

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 Michael Warwick was found hanged in his cell at HMP Hull on 5 November 2019. He was 26 years old. I offer my condolences to Mr Warwick's family and friends.

Mr Warwick had a number of risk factors that indicated he was at high risk of attempted suicide and self-harm. He was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) at HMP Humber but these were stopped, inappropriately, the day before he moved to Hull for a court appearance.

I am concerned that, despite receiving information from Humber that Mr Warwick was in the post-closure phase of ACCT monitoring, prison and healthcare staff at Hull missed several opportunities to identify his risk and start ACCT monitoring. In addition, the clinical reviewer concluded that the mental health care afforded to Mr Warwick at Hull was not equivalent to that he might have expected to receive in the community.

We also found deficiencies in the application of the incentives and earned privileges (IEP) scheme. In addition, there was a ten-minute delay before an emergency code and ambulance were called, although this did not affect the outcome for Mr Warwick.

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 CBE
Prisons and Probation Ombudsman

January 2023

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Summary

Events

1. In January 2018, Mr Michael Warwick was sentenced to two years for burglary. He was released on licence from HMP Humber in January 2019. He was recalled to HMP Hull in May and June for two separate 28 day recalls for breaching his licence conditions. He was recalled to Hull a third time on 23 September 2019 to serve the remaining nine weeks of his sentence. He had a history of attempted suicide, self-harm, mental illness and substance misuse.
2. Mr Warwick transferred to HMP Humber on 1 October. He was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) for the duration of his time there after he threatened to harm himself. ACCT monitoring was stopped on 8 October, the day before he transferred to Hull for a court appearance.
3. Reception staff at Hull did not identify that Mr Warwick was in the post-closure phase of ACCT monitoring. Despite a range of risk factors, he was assessed as being at low risk of suicide and self-harm.
4. On 28 October, a mental health assessment showed Mr Warwick needed treatment for depression and severe anxiety. Mr Warwick said he would be better off dead and that he thought about harming himself several days a week. Mr Warwick did not receive any treatment for depression or anxiety before he died and no one considered starting ACCT procedures.
5. On the evening of 4 November, prison officers removed two cupboards from Mr Warwick's cell after he used them as a barricade. Later that night, Mr Warwick asked for the Samaritans telephone number.
6. At 4.41am on 5 November, an operational support grade (OSG) saw Mr Warwick apparently standing against the back wall of his cell. Two minutes later she returned to the cell and he had not moved. She telephoned the night custodial manager and asked him to come to the cell. She went back to the cell a third time at 4.47am. She was unable to obtain a response from Mr Warwick and radioed for assistance.
7. At 4.50am, the custodial manager and two officers arrived and went into the cell. Mr Warwick was hanging from the window bars. They radioed a medical emergency code and started cardio-pulmonary resuscitation (CPR). Ambulance staff arrived at approximately 5.07am and confirmed that Mr Warwick had died.

Findings

8. Staff at Humber should not have stopped ACCT procedures the day before Mr Warwick moved to Hull.
9. We found failings in the identification and assessment of Mr Warwick's risk when he arrived at Hull on 9 October. Reception staff did not recognise that he was in the

post-closure phase of ACCT monitoring or that he had several risk factors for suicide and self-harm.

10. A member of the mental health team did not begin ACCT procedures after Mr Warwick told him that he would be better off dead and thought about harming himself on several days a week.
11. The clinical reviewer concluded that the mental health care Mr Warwick received at Hull was not equivalent to that which he could have expected to receive in the community. Healthcare staff did not assess him appropriately when he arrived at Hull in view of his history of self-harm.
12. Mr Warwick was not given the opportunity to appeal against the decision to place him on the basic regime and staff did not follow the prison's IEP policy.
13. The OSG did not act with sufficient urgency when she saw Mr Warwick apparently standing in his cell at 4.41am on 5 November, and there was a ten minute delay before an emergency code and ambulance were called.

Recommendations

For HMP Humber:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.

The Governor should ensure that this report is shared with the supervisor officer and that a senior manager discusses the Ombudsman's findings with him.

For HMP Hull:

The Governor of Hull should ensure that reception, first night staff and all others who assess risk:

- consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm;
- note and consider all information from all available records including person escort records (PERs); and
- open an ACCT if a prisoner indicates that he is at risk of attempted suicide and self-harm, irrespective of his demeanour.

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- night staff enter cells as quickly as possible in a life-threatening situation; and
- night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.

The Head of Healthcare should ensure that newly arrived prisoners who are referred to the mental health team receive a face to face assessment.

The Head of Healthcare should ensure that all staff understand their responsibility to start ACCT procedures if a prisoner may be at risk of suicide or self-harm.

The Governor should ensure that staff adhere to the national guidelines for the IEP scheme, particularly that prisoners are set appropriate targets and have the opportunity to make representations at an appeal.

The Governor should ensure that staff are aware of their responsibilities under PSO 1700 when items of furniture are removed from a cell.

The Governor should ensure that this report is shared with the custodial managers, the supervisor officers, the officers and the operational support grade and that a senior manager discusses the Ombudsman's findings with them.

The Head of Healthcare should share this report with the nurses and recovery worker and discuss the Ombudsman's findings with them.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Warwick's prison and medical records.
16. NHS England commissioned a clinical reviewer to review Mr Warwick's clinical care at the prison. The investigator and the clinical reviewer interviewed 14 members of staff at Hull on 22, 23 and 24 January 2020. The investigator interviewed two members of staff at HMP Humber on 26 February.
17. Our investigation was delayed while we waited for the clinical review.
18. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. We wrote to Mr Warwick's partner, his nominated next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Warwick's partner asked if he had broken his nose before he died. We have addressed her question in this report.
 - Mr Warwick's partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
 - The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Hull

20. HMP Hull is a local prison that holds up to 1,056 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison has a wellbeing unit to support prisoners with complex needs, which are difficult to meet in the normal prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hours service at other times.

HM Inspectorate of Prisons

21. The most recent full inspection of HMP Hull was in April 2018, and HMIP had concerns in many areas. Inspectors found an increase in prisoners taking their own lives and incidents of self-harm. Although they acknowledged that the prison was working hard to tackle this, inspectors were concerned about the quality of casework for those in crisis and felt there was a greater need to offer support to vulnerable prisoners. Despite an increase in violence, inspectors noted that most prisoners felt safe, respected and knew of someone they could turn to for help. Inspectors found strong leadership and a positive staff culture which helped to maintain reasonably good outcomes for prisoners during challenging times.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2019, the IMB reported that prisoners were treated fairly and humanely and every effort was made to prepare them for release. A total of 792 ACCT documents were opened in the reporting year, compared with 752 in the previous year. The Board found the documents and checks to be up to date and accurate and ACCT procedures were used effectively.

Previous deaths at HMP Hull

23. Mr Warwick's death was the fifteenth at Hull since November 2017. Of the previous deaths, nine were from natural causes, one was drug-related, and three were self-inflicted. One death is awaiting classification. There have been two deaths since: one from natural causes and one prisoner took their own life. We have previously made a recommendation about the use of emergency codes.

Assessment, Care in Custody and Teamwork

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.
25. 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.

26. 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.

Incentives and Earned Privileges (IEP) scheme

27. 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 three levels: basic, standard and enhanced.

Key Events

28. On 19 January 2018, Mr Michael Warwick was sentenced to two years in prison for burglary and sent to HMP Humber. He had been in prison before. Mr Warwick had a history of threatened and attempted suicide, self-harm, substance misuse, arson and mental health issues. He was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) on five occasions during 2018 for swallowing batteries (twice), swallowing a razor blade, setting fire to his cell and cutting himself.
29. On 10 January 2019, he was released on licence. He was recalled to HMP Hull on 17 May and 21 June for two separate 28 day recalls for breaching his licence conditions. Mr Warwick was recalled to HMP Hull a third time on 23 September 2019, after breaching a restraining order preventing him from contacting the mother of his son. He had nine weeks of his sentence left to serve.

HMP Humber

30. On 1 October 2019, Mr Warwick moved to HMP Humber on a routine prison transfer. A custodial manager began ACCT procedures because Mr Warwick said he was:
 - unhappy at being returned to custody;
 - his child had been taken into care;
 - he did not have credit to use the prison telephone system;
 - he did not want to be in Humber; and
 - he could not see himself completing his sentence.

The custodial manager completed Mr Warwick's immediate action plan and placed him on five observations an hour.

31. On 2 October, a custodial manager carried out an ACCT assessment. Mr Warwick said he had difficulty sleeping and wanted to work with the mental health team. Mr Warwick spoke about his son and said he had no thoughts of suicide or self-harm.
32. A senior officer completed the first case review. Mr Warwick said he felt anxious because he could not sleep and he was unable to telephone his friends and family. A mental health nurse said he would refer to a prison GP to investigate his sleeping problems and offered him support from the mental health team. The same day credit was added to Mr Warwick's prison telephone account.
33. Mr Warwick asked for the ACCT to be closed because he had no thoughts of suicide or self-harm. SO Woodward assessed Mr Warwick's risk of suicide or self-harm as low and reduced his observations to one an hour during the day and one observation every two hours during the night.
34. On 4 October, a supervisor officer chaired an ACCT case review. Mr Warwick said he had no thoughts of suicide or self-harm and again asked for the ACCT to be

closed. A mental health nurse said that Mr Warwick was working with the mental health team and the GP had prescribed sleeping tablets. The supervisor officer noted that Mr Warwick appeared stressed and decided the ACCT would remain open.

35. The same day, an administration officer at Humber sent an email to the safer prisons team administration officer at Hull, to tell her that Mr Warwick would be moving to Hull on 9 October for a court appearance to appeal against his recall to prison.
36. On 7 October, a further email was sent to the safer prisons team administration officer to tell her that Mr Warwick was subject to ACCT monitoring. On 8 October, the safer prisons team administration officer sent an email to reception (the dedicated arrival point for prisoners), the safer custody team and three supervisor officers from G wing (the induction wing) to tell them that Mr Warwick would arrive at Hull the next day and was subject to ACCT monitoring. The safer prisons team administration officer could not remember if she received a response.
37. On 8 October, a supervisor officer chaired an ACCT case review, attended by another supervisor officer and a mental health nurse. The supervisor officer noted that Mr Warwick had received support from the mental health team and would shortly move to Hull. Mr Warwick said he was happy to move and did not want to return to Humber. Mr Warwick's risk level remained unchanged and ACCT monitoring was stopped. He also noted that the post-closure phase would end on 15 October. An alert to this effect was added to Mr Warwick's NOMIS record (his electronic prison record).

HMP Hull

38. Mr Warwick arrived at Hull at about 2.00pm on 9 October. On the front page of his Person Escort Record (PER), which accompanied him from Humber to Hull, prison staff recorded that an ACCT had been opened on 1 October and the post closure phase started on 8 October.
39. A mental health nurse completed Mr Warwick's initial health assessment at Hull using a new national template for transferred prisoners introduced in October 2019. She noted his history of anxiety and depression and referred Mr Warwick to the mental health team.
40. At interview the mental health nurse said it was her practice not to start her assessment without the medical record and the PER. She said she might not have been able to see Mr Warwick's notes from Humber on the medical record and in practice did not have time to read back through them in reception assessments. She did not remember Mr Warwick's PER specifically. She said reception staff photocopy the front page of the PER and this is later scanned into the medical record. She has the PER and the photocopied page with her when she completes initial health assessments and then the PER goes with the prisoner to the first night induction interview. The prison were unable to find Mr Warwick's PER but the front page was scanned into his medical record.
41. The mental health nurse wrote in the medical record:

“History of self-harm and suicidal ideation has tried to set fire to himself, tried to hang himself and tried to overdose. He states that he has no current thoughts or feelings of self-harm or suicide and has been informed of the support services available to himself whilst in prison. He states that if he needed, he will utilise these services. Has maintained good amounts of eye contact and communicated appropriately throughout the assessment. Following the completion of health screening a decision to open an ACCT document has been deemed unnecessary at this moment in time.”

She entered ‘no’ in the question boxes that related to recent attempted suicide and ACCT monitoring. She said she could not remember why she had recorded contradictory information about Mr Warwick’s history of suicide and self-harm but she had not been trained in completing the new template. She thought that the information had come from Mr Warwick rather than his records and said she must have missed the information about ACCT on the PER.

42. An officer completed Mr Warwick’s first night induction interview in reception. She could not remember if she saw Mr Warwick’s PER and told us that prisoners should not leave reception without a copy of it in their file. She recorded in Mr Warwick’s NOMIS (electronic prison record) that he did not raise any issues about self-harm but she did not check the alert section that showed he was in the post-closure phase of ACCT monitoring. Mr Warwick was allocated a single cell on G wing.
43. On 10 October, a prison GP, saw Mr Warwick to discuss his difficulty sleeping. She noted that Mr Warwick had been prescribed zopiclone (a sleeping tablet) at Hull. The prison GP told Mr Warwick this was prescribed for short-term use and gave him Nytol (an antihistamine that causes drowsiness). She referred Mr Warwick to the prison’s mental health team.
44. The same day, a mental health nurse triaged Mr Warwick for his mental health referral. The mental health nurse recorded that Mr Warwick said he had been “ruminating on thoughts throughout the night” and that he had reported a long history of self-harm. He triaged Mr Warwick as ‘green’ which indicated that he was at low risk and would receive an appointment with the mental health team within fourteen days. (Prisoners triaged as ‘amber’ and ‘red’ are seen by mental health nurses in a shorter time frame. Prisoners triaged as green are seen by support time recovery workers - a non-clinical role used to gather information by questionnaire for discussion at mental health team meetings.)
45. On 11 October, Mr Warwick moved to a single cell on C wing and was given a job in the catering department. One of the officers became Mr Warwick’s keyworker. She noted that Mr Warwick was pleased to be at Hull and hoped to remain there until his release in December. Officer Prowse said she was unaware that Mr Warwick was in the post-closure phase of ACCT monitoring and she did not check the alert section of his NOMIS.
46. On 22 October, a nurse saw Mr Warwick at the medication hatch. Mr Warwick said he had been sick during the night and she advised him to take the day off work and return to the medication hatch the next morning. She did not issue Mr Warwick with a fitness to work note and he did not return to the medication hatch or go to work the next morning. The same day, an officer Mr Warwick two Incentives and Earned Privileges (IEP) scheme warnings for refusing to attend work.

47. On 28 October, a supervising officer gave Mr Warwick an IEP warning for vaping at his desk in education. The supervising officer placed Mr Warwick on the basic regime because he had received three IEP warnings in a period of four weeks. He told the investigator that Mr Warwick's NOMIS did not record why he had refused to attend work. The supervisor officer did not ask Mr Warwick why he had not attended work or explain how he could appeal against the decision to place him on basic regime and what he needed to do to return to standard level. A review was arranged for 4 November.
48. Also on 28 October a support time recovery worker, went to see Mr Warwick to assess him using a combined questionnaire that measures anxiety and depression. The questionnaire indicated that Mr Warwick had moderately severe depression and severe anxiety. During the assessment Mr Warwick said that he would be better off dead and thought about hurting himself several days a week.
49. The support time recovery worker told the investigator that Mr Warwick appeared upbeat during the assessment and was talking about his future plans. He did not access the medical records due to Mr. Warwick being triaged by another member of the mental health team and he was unaware of Mr Warwick's previous history of self-harm. The support recovery worker said he had access to NOMIS but did not look at it as part of his role in mental health assessment. He did not consider starting ACCT monitoring procedures.
50. An entry on Mr Warwick's medical record showed he was low in mood and had suicidal thoughts. He asked for antidepressants to stop his mood worsening, said he was still struggling to sleep and felt he had unfairly been put on the basic level of the IEP scheme.
51. On 29 October, Mr Warwick did not attend his video-link court appearance. He told an officer that he refused to attend because he did not want to wait in the holding cell. On 30 October, an officer gave Mr Warwick two IEP warnings for refusing to attend work.
52. On 1 November, a mental health multi-disciplinary team meeting (MDT) discussed the information gathered by the support recovery worker and concluded that Mr Warwick was suitable for group therapy. Mr Warwick did not see a member of the mental health team again before he died.
53. Mr Warwick's prison telephone calls indicated that he was frustrated about being put on the basic regime. In his last call, to his mother on 3 November, he sounded positive and was anticipating being taken off the basic regime and being given a TV.
54. On the same day, 3 November, a senior officer reviewed Mr Warwick's IEP level. he noted on Mr Warwick's NOMIS that he had received three IEP warnings in the past seven days and would remain on the basic regime until another review on 11 November. The senior officer told the investigator that he did not complete the IEP paperwork and he did not set any targets to enable Mr Warwick to return to standard regime. The senior officer spoke to Mr Warwick at his cell door and told him he would remain on basic. There is no evidence that Mr Warwick had received three IEP warnings and he could not explain why he had noted this on Mr Warwick's NOMIS.

Events of 4 November

55. At approximately 7.00pm on 4 November, an officer went to Mr Warwick's cell and found that he had covered his observation panel. The officer was unable to open Mr Warwick's cell because he had placed two cupboards against the cell door. Mr Warwick said he was unhappy about being kept on the basic regime and the removal of his television. He agreed to uncover the observation panel but would not remove the cupboards. The officer told the investigator that he informed his superior that Mr Warwick had barricaded his cell.
56. The supervisor officer contacted the custodial manager for advice. The Custodial manager asked officers to remove the cupboards from Mr Warwick's cell. CCTV shows an officer speaking at Mr Warwick's cell door at 7.22pm. Shortly after, the officer and five prison officers entered Mr Warwick's cell and removed two cupboards. The custodial manager told the Investigator he did not consider that removing the cupboards meant that Mr Warwick's cell was subject to special accommodation procedures.

Events of 5 November

57. At approximately 10.10pm, Mr Warwick asked an Operational Support Grade for the Samaritans telephone number. The operational support grade said that because prisoners have in-cell telephones, she passed the number under Mr Warwick's cell door. Despite being aware that Mr Warwick had barricaded that evening, she did not ask Mr Warwick how he was feeling or inform the custodial manager (who was in charge of the prison that night) that he wanted to contact the Samaritans.
58. At approximately 4.30am, the operational support grade started the early morning roll count. CCTV shows her turning on the cell night light and looking through Mr Warwick's observation panel at 4.41am. She said Mr Warwick appeared to be standing against the back wall of his cell, facing the window. She felt uneasy because it was an unusual time for a prisoner to be standing in his cell. She returned to Mr Warwick's cell at 4.43am and looked through the observation panel again. The operational support grade said she was unable to obtain a verbal response from Mr Warwick, so she telephoned the custodial manager and asked him to come to the cell. She said she did not radio an emergency code because she had been unsure whether Mr Warwick was trying to trick her into going into the cell.
59. At 4.47am, the operational support grade returned to Mr Warwick's cell and radioed for assistance because Mr Warwick was still in the same position. At 4.48am, the operational support grade asked for permission to enter Mr Warwick's cell but did not receive a response. She did not use an emergency code on either of these occasions.
60. At 4.50am, the custodial manager and two officers arrived at Mr Warwick's cell. The custodial manager looked through the observation panel and saw Mr Warwick had an orange ligature around his neck (his blanket) and had hanged himself from the window bars. One of the officers radioed an emergency code blue (which indicates a prisoner is unconscious or not breathing). They went into the cell and the officer used her anti-ligature knife to cut the ligature. The custodial manager said Mr Warwick's legs were stiff and they had trouble getting him down. He started

cardiopulmonary resuscitation (CPR) on the bed. The control room called an ambulance at 4.52am.

61. At 4.57am, some six minutes after the code blue was called, a nurse arrived and noted that Mr Warwick's skin was tinged blue, his tongue was swollen and his face was grey. There were no signs of life and Mr Warwick did not have a pulse. She attached a defibrillator which did not detect a shockable rhythm. At 5.07am, paramedics arrived and confirmed that Mr Warwick had died.

Contact with Mr Warwick's family

62. The prison appointed a family liaison officer (FLO) and identified Mr Warwick's partner as his next of kin. At 11.00 am, the family liaison officer and the Head of Safer Prisons, travelled to Mr Warwick's partner's address and broke the news of his death.
63. The prison contributed to the cost of Mr Warwick's funeral in line with national guidance.

Support for prisoners and staff

64. After Mr Warwick's death, the Deputy Governor, 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.
65. The prison posted notices informing other prisoners of Mr Warwick'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 Warwick's death.

Post-mortem report

66. The pathologist concluded that Mr Warwick died from hanging. The toxicology report did not detect any illicit substances in Mr Warwick's blood. The post-mortem did not detect any facial injuries.

Findings

ACCT procedures

67. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, advises that a transfer between prisons – even if it is a positive move – is known to increase risk. It says:

“ACCT Plans must not be closed to facilitate a transfer to another prison or within 72 hours of a planned transfer. Where a transfer takes place within the post-closure period, the receiving prison must be informed about the recent ACCT and the need for them to undertake the post-closure review.”

We consider that Humber should not have stopped ACCT monitoring on Mr Warwick. He listed several reasons for his unhappiness when ACCT monitoring was started and most of these were still factors when he moved to Hull. ACCT monitoring should identify issues and make a plan to tackle them to reduce risk. It is unclear how Mr Warwick’s risk had reduced sufficiently for ACCT monitoring to be stopped. Although he welcomed a move to Hull, the purpose of his transfer was to attend a court appearance by videolink. Court appearances are also known to increase risk and, in addition, depending on the outcome, it was possible that he would have returned to Humber.

68. We make the following recommendations:

The Governor of Humber should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.

Identification of Mr Warwick’s risk of suicide and self-harm.

69. PSI 64/2011 and PSI 74/2011, *Early Days in Custody*, both list a number of risk factors and potential triggers for suicide and self-harm. Mr Warwick had several of these risks including attempted suicide, previous self-harm, poor mental health, substance misuse, relationship instability, licence recall, transfer to another prison and a court appearance.
70. The PER that accompanied Mr Warwick to Hull on 9 October noted that he was in the post-closure phase of ACCT monitoring. The safer prisons administrator at Humber had emailed this information to her counterpart at Hull prior to transfer, who in turn had informed reception and first night centre staff. The information was also on Mr Warwick’s NOMIS record and the ACCT document was in his core record. We are concerned that, despite this prison and healthcare staff at Hull missed several opportunities to identify Mr Warwick’s risk of suicide and self-harm:
- The nurse and the officer in reception when Mr Warwick arrived both failed to read his PER or identify that he was in the post-closure phase of ACCT monitoring or to consider his risk factors.

- The mental health nurse who assessed Mr Warwick's mental health on 10 October concluded he was at low risk despite information to the contrary in his medical record.
- On 28 October, Mr Warwick told the member of the mental health team who assessed him that he would be better off dead and that he thought about hurting himself on several days a week, but no consideration was given to opening an ACCT, despite the fact that Mr Warwick was assessed as having depression and severe anxiety.
- On 1 November, a mental health multi-disciplinary team meeting (MDT) reviewed Mr Warwick on paper, including the information gathered on 28 October, and concluded that he was suitable for group therapy.
- On 4 November, Mr Warwick barricaded his room and later asked for the Samaritans telephone number.

71. We consider the range of Mr Warwick's risk factors alone should have caused concern. Instead, there was too much reliance on his behaviour and what he said, rather than an objective evaluation of all risk factors. We make the following recommendation:

The Governor of Hull should ensure that reception, first night staff and all others who assess risk:

- **consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm;**
- **note and consider all information from all available records including person escort records (PERs); and**
- **open an ACCT if a prisoner indicates that he is at risk of attempted suicide and self-harm, irrespective of his demeanour.**

Emergency response

72. At night, officers have a key in a sealed pouch for use in an emergency. PSI 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.
73. We do not criticise the operational support grade for not entering Mr Warwick's cell immediately and alone when she was unable to get a response from him. However, we consider that she should have acted with more urgency to summon assistance by using her radio instead of the telephone. In these circumstances, when a prisoner is unresponsive, we consider that staff should assume the worst and act with urgency. The operational support grade knew that Mr Warwick had barricaded his cell at 7.00pm and had asked her for the Samaritans telephone number at

10.10pm. It was also an unusual time for a prisoner to be standing at the back of their cell not moving. CCTV showed she was sufficiently concerned to return to Mr Warwick's cell twice in relatively quick succession.

74. The operational support grade lack of urgency led to a delay of some ten minutes before a code blue was called and emergency services were summoned. There was a further delay of six minutes before the prison nurse arrived. We cannot say that the delay affected the outcome for Mr Warwick but early intervention is crucial to improving the outcome in cases of hanging.

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **night staff enter cells as quickly as possible in a life-threatening situation; and**
- **night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.**

Mental Health

75. The clinical reviewer concluded that Mr Warwick's mental health care was not equivalent to what he would have received in the community.
76. We agree with the clinical reviewer that all newly arrived prisoners referred to the mental health team should receive a face-to-face assessment rather than a desktop assessment.
77. When he did have a face-to face assessment 18 days later on 28 October, Mr Warwick told the recovery worker that he would be better off dead and had considered hurting himself on several days a week and was assessed as needing treatment for moderately severe depression and severe anxiety. This did not happen before he died and Mr Warwick did not see a member of the mental health team again before his death.
78. We share the clinical reviewer's concern that, despite the assessment on 28 October, the MDT assessed Mr Warwick as suitable for group work on 1 November.
79. We are also concerned that although the recovery worker had access to Mr Warwick's NOMIS, he did not look at it and was, therefore, not aware of his previous history of self-harm. We do not consider that this was good practice but, in any case, we are concerned that the recovery worker did not consider opening ACCT procedures in the light of what Mr Warwick said about his frequent thoughts of suicide and self-harm.
80. We recommend that:

The Head of Healthcare should ensure that newly arrived prisoners who are referred to the mental health team receive a face to face assessment.

The Head of Healthcare should ensure that all staff understand their responsibility to start ACCT procedures if a prisoner may be at risk of suicide or self-harm.

Review of Mr Warwick's IEP status

81. Mr Warwick's IEP level was reduced to basic on 28 October for seven days. Hull's local IEP policy requires staff to set behavioural targets to establish how to achieve progression to standard level, and says that wing staff should make daily entries about behaviour in their prison records and inform prisoners of the appeals process. This did not happen. There is evidence that Mr Warwick was upset at being on the basic regime in the days before he was found hanged and considered that he had been treated unfairly. We make the following recommendation:

The Governor should ensure that staff adhere to the national guidelines for the IEP scheme, particularly that prisoners are set appropriate targets and have the opportunity to make representations at an appeal.

Special accommodation

82. Prison staff removed two cupboards from Mr Warwick's cell on the evening of 4 November after he used them to barricade in his cell. PSO 1700, *Segregation*, defines special accommodation as "a dedicated cell, or improvised normal accommodation with any one (or more than one) of the following items removed in the interest of safety: furniture, bedding and sanitation". Special accommodation can be located anywhere in a prison, including healthcare, and is not only found in segregation units. The PSO makes it clear that prison staff must observe those in special accommodation a minimum of five times an hour.
83. The prison's internal investigation concluded that the removal of the two cupboards should have triggered the special accommodation protocol and that Mr Warwick should have been observed at least five times an hour. We consider that the combination of factors – the barricading, the removal of some furniture and the request for the Samaritans phone – should have led staff to recognise that Mr Warwick was in distress and to have considered whether an ACCT should be opened.
84. We therefore recommend that:

The Governor should ensure that staff are aware of their responsibilities under PSO 1700 when items of furniture are removed from a cell.

Learnings lessons

85. We consider that it is important for staff who were involved in Mr Warwick's care to see the findings of and learn lessons from our investigation. We make the following recommendations:

The Governor of HMP Humber should ensure that this report is shared with the supervising officer and that a senior manager discusses the Ombudsman's findings with him.

**Prisons &
Probation**

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