Investigation into the death of a man at the Princess Royal Hospital, Telford, while a prisoner at HMYOI Stoke Heath in December 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of the investigation into the death of the man who died in December 2010 at Princess Royal Hospital, Telford. The man had been found in his cell at HMYOI Stoke Heath two days earlier hanging from a ligature tied to the window bar. The man was 18 years old at the time of his death.

I extend my sincere condolences to his family and friends. I also apologise for the delay in issuing this report.

Her Majesty's Coroner for Mid and North West Shropshire District requested that a post mortem examination be conducted. The result of his death was noted to be "hanging".

One of my investigators was appointed on my behalf and he was assisted by his colleague. A review of the man's medical care was commissioned with Shropshire County Primary Care Trust (PCT). I am grateful to the clinical reviewer for carrying out that review.

I would also like to thank the Governor of Stoke Heath and his staff for their co-operation and assistance. I give special thanks to Governor B for his help as investigation liaison officer. I also extend my thanks to the staff at the Stoke Youth Offending and Probation Service, of whom had known the man and provided input into this investigation.

The man was a troubled young man. In 2009, he made a serious suicide attempt whilst in custody at Stoke Heath. However, he was discovered by staff and, following a period of three days in hospital, he made a full recovery. Although interventions were provided after this suicide attempt to help him improve his outlook on life, medical professionals found it difficult to fully engage with him, and believed he would try to harm himself at some point in his life. They believed this would be difficult to predict.

On the evening before the man's death, there was no indication that he might harm himself and indeed he had played pool with his brother (who was also in custody) during the association period.

I make four recommendations as a result of this investigation, which primarily relate to staff training for completing the TAG (Threshold Assessment Grid) mental health assessments, healthcare staff attending ACCT reviews, first aid training and the inclusion of notable events of self harm in the Safeguarding Meeting minutes.

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

Thea Walton
Acting Deputy Ombudsman **January 2012**

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SUMMARY

1. In October 2009, the man made a serious attempt to harm himself whilst on remand at HMYOI Stoke Heath. He was found in his cell hanging by staff and sent out to hospital. The life support machine was turned off and he was not expected to survive. However he made a full recovery. The Governor approached the Local Authority Children's Services to propose a serious case review but the decision was made that a file review was sufficient. The Governor attended the review and also protested to the Youth Justice Board (YJB) saying that the man should not be in custody. The decision that he was originally placed into custody was ultimately made by the courts. The YJB had however suggested on 19 October that a referral to the Keppel unit (based in Wetherby YOI to provide enhanced support to 15 to 17 year-old young men who for a variety of reasons are not engaging, or are unlikely to engage, with the normal regime in a YOI) should be considered.

2. The man returned to Stoke Heath from hospital and was immediately supported with self harm monitoring and located in the healthcare unit. The Independent Monitoring Board (IMB) members met him regularly at self harm monitoring review meetings. He told them that he harmed himself because he was bored.

3. He was also referred to the local Child & Adolescent Mental Health team (CAMHS[1]). Staff from CAMHS assessed the man but did not think that he had a diagnosable mental illness. Due to the severity of the act of self harm he had committed, the CAMHS team kept him on their caseload.

4. The Stoke Youth Offending Team (YOT) subsequently arranged intensive fostering[2] and the man was bailed to their care in November 2009. However, he absconded within a day and committed further offences. He was returned to custody, where he remained until May 2010 before being released. During this period he was monitored under suicide and self harm procedures having been found to have made superficial cuts to his arm and having made a ligature.

5. The man was released from custody on 21 May 2010 before returning on 24 September, on remand, for the offence of burglary and robbery. He was later sentenced to 20 months imprisonment. He started this period of custody at

[1] CAMHS are part of the National Health Service (NHS) and works to support and help young people and their families. CAMHS specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties.

[2] After sentencing, the young person is sent to the foster family for six to nine months, with social workers, family therapists and liaison officers on call. The programme is strict: to enjoy privileges such as watching television, participants must earn points for good behaviour by, for example, doing their homework and going to bed on time. It is purposely childish: intensive fostering is designed to reprogramme the young person's experience of childhood.

HMYOI Brinsford where he was again monitored under suicide and self harm procedures after a ligature was found in his cell. Aware of his previous serious self harm attempt at Stoke Heath, he was regularly seen by the mental health team, who had concerns about his ability to communicate. Because of this, they had also had difficulties in undertaking an accurate assessment. Having provided a lot of input into his needs, the YOT informed Brinsford that there was a clear heightened risk of self harm reoccurring in context of his return to custody. Monitoring under the suicide and self harm procedures stopped on 10 November.

6. Having been sentenced, the man was transferred to Stoke Heath on 12 November. He was not subject to suicide and self harm procedures. As staff were aware of his previous attempts to harm himself, he was assessed by the mental health team. Again no mental illness was diagnosed. He was offered the chance to share a cell with his older brother, who was on the same wing, but declined. There were no initial concerns raised about his demeanour.

7. While he was at Stoke Heath, he was twice given support with suicide and self harm procedures. Following the second occasion, he was reported by staff to have improved in the way he interacted with his peers and staff. By the time the ACCT procedures were closed, he was making better use of his time and no concerns were raised that he might self harm.

8. The man had a girlfriend and it appeared they had a volatile relationship. He telephoned her a number of times whilst at Stoke Heath. Although there relationship appeared to have broken down shortly before he hanged himself, there was no sign from his last telephone conversation with her on 19 December that he intended to harm himself.

9. In December, during the evening roll check, the man was found hanging in his single cell at around 8.50pm. Help was immediately summoned and staff, including healthcare nurses, attended his cell. Resuscitation began immediately and an ambulance was called. The paramedics arrived and his pulse had been restored. He was subsequently transferred to Princess Royal Hospital in Telford. He was sedated and placed on a ventilator. Unfortunately he was pronounced brain dead.

10. I make four recommendations as a result of this investigation, which primarily relate to staff training when completing the TAG mental health assessments, healthcare staff attending ACCT reviews, first aid training and the inclusion of notable events of self harm in the Safeguarding Meeting minutes

THE INVESTIGATION PROCESS

11. The then Acting Prisons and Probation Ombudsman opened the investigation into the man's death in December 2010, when she visited Stoke Heath. She met with the Governor of Stoke Heath, liaison officer, Governor B, the chair of the Independent Monitoring Board, (IMB). (The IMB are volunteers drawn from the community who monitor the day to day life of the prison, its staff and prisoners.) The Acting Prisons and Probation Ombudsman also met with members of the safer custody team, the chair of the Prison Officers Association (a trade union for prisons) and the clinical manager. Notices of the investigation and the Ombudsman's terms of reference were sent in advance of her visit.

12. Later, the Acting Prisons and Probation Ombudsman visited the man's cell and spoke to his brother, who was also at Stoke Heath on the same wing. She asked for copies of the man's prison and medical file to be forwarded to her investigator.

13. One of my investigators was commissioned a clinical review of the man's medical care while he was at Stoke Heath, from Shropshire County PCT. The clinical reviewer undertook that review. A review panel also contributed to the review process. I extend my thanks to the clinical reviewer and the panel for their contribution.

14. Another of my investigators and the clinical reviewer visited Stoke Heath with the investigator on 8 and 9 February 2011, to interview prison and healthcare staff. They returned to the prison on 14 and 15 March, for further interviews. At this stage feedback was provided to the Governor covering some of the main issues which had arisen during the course of the investigation.

15. The investigation team also contacted Stoke Youth Offending Team (YOT) and Stoke Probation Service and I would like to thank them for their assistance. They shared their records and knowledge of the man and I do not underestimate the value of the work they did with him in the time they had contact with him.

16. One of the Ombudsman's Family Liaison Officers contacted the man's mother and father to inform them of the investigation and give them an opportunity to raise any questions or concerns about the care their son received. My investigator and my family Liaison Officer met the man's parents during the course of the investigation. His brother, who had been released from custody soon after the man's death, was unable to attend the meeting due to ill health. The family raised a number of concerns which I have listed below:

    - The man's parents believed that prison was not the right place for him because of his vulnerability.

    - The man's parents asked why he was in a cell on his own. What time was he discovered and how long had he been hanging in his cell?

- The family had had no contact with his girlfriend. They believed however that he had spoken to her prior to his death.

17. Once completed, a copy of the investigation draft report was sent to the man's family's legal representatives at that time, on Thursday 1 September 2011. However a number of weeks after receiving the investigation draft report, on the 11 October 2011 the legal representatives returned the report to the Ombudsman's office. They explained that they had been unable to make contact with the man's family and therefore take instructions. They had taken the decision that they were therefore unable to continue to act on behalf of the family.

18. The Ombudsman's liaison officer then attempted to contact the family by telephone and wrote a letter on 25 October 2011 after being unsuccessful in making contact on the phone. The family were offered the opportunity to receive and comment on the draft version of the report, however, to date this office has not received any further contact from the man's family. I hope that the findings of this investigation answer any questions they may have, should they receive the report in the future.

THE MAN

19. The man was born in Stoke on Trent. He was one of ten children and attended a school for children with special needs. However, it was noted in his probation service notes that his parents were subject of criminal proceedings for failing to ensure the man went to school. He had poor reading and writing skills and failed to attain any formal qualifications. He also had no employment history. He had difficulty in communicating effectively and coping in everyday life, which made him vulnerable to manipulation from others.

20. Up to the time of his death it was recorded that he had 13 convictions dating back to 2003. These predominantly related to financially motivated and risk taking antisocial behaviour, such as driving related offences and criminal damage. This was not his first time in custody.

21. A psychological report was undertaken on 9 March 2010 whilst the man was on remand at Stoke Heath after his suicide attempt. The doctor concluded that the man had specific learning difficulties. He had a reading and vocabulary age of below six years of age, problems expressing himself verbally and struggled to talk about his thoughts and feelings. The doctor could not find evidence that the man had a mental health illness, although he did find emotional and psychological problems. The doctor said,

> "He [the man] has very low self esteem and a very poor sense of self worth. He places little value on his life. He seems have had a few areas of success in his life and struggles to find activities that he finds rewarding.
>
> "[The man] reacts impulsively to life events, he has poor ability to reflect and consider his predicament or consequences of his actions and is unable to effectively explore courses of actions when faced with choices"

22. A pre-sentence report was written by a probation officer in November 2010. The report states that the man openly admitted to his previous suicide and self harm attempts and had little regard for his own life.

HMYOI STOKE HEATH

23. Stoke Heath was built in 1964 as a category C adult prison. Two years later, it was converted, and was used to hold young offenders between the ages of 15 and 21, although recently Stoke Heath no longer holds prisoners between the ages of 15-17. The accommodation for young adults consists of five main residential units, B, E, F, G and I Wings. E and I Wing consist of double cells, while B, F and G Wings have a mixture of single and double cells.

24. The healthcare unit is a new two storey centre and was opened in July 2004. It has eight in-patient rooms, all of safer cell (a cell designed to have a reduced number of ligature points) construction and with CCTV. There is a GP led healthcare team providing general healthcare, clinics, dental services, podiatry, optometry services and healthcare and lifestyle advice. The team also provides primary mental health services. These services are directly provided by Shropshire County Primary Care Trust. Secondary mental healthcare is provided via a prison in-reach team run by South Staffordshire and Shropshire Healthcare Foundation Trust. For under 18s, this service was provided by the Child and Adolescent Mental Health Service (CAMHS) run by Telford and Wrekin Primary Care Trust.

25. The former HM Chief Inspector of Prisons carried out an unannounced inspection of Stoke Heath in April 2010. In her summary, she said:

> "Stoke Heath Youth offenders' institution is one of only two remaining 'split sites', holding both young adults (aged 18 to 21) and young people (aged 15 to 17). This inspection was solely of the provision for young adults. This is an age group about which the Inspectorate has repeatedly expressed concern: that the focus and the resources available are inadequate to meet their needs and risks. This report amply demonstrates that concern. In many key areas, we found that young adults' access to important activities and opportunities was severely limited."

26. Furthermore, the former HM Chief Inspector of Prisons said in respect of self harm and suicide prevention,

> "There were several strategies, policies and protocols covering safer custody, suicide prevention and self-harm management across the prison. The approach was confusing and there was a lack of clarity on strategy for young adults. The current strategy document was concerned too simplistically with assessment, care in custody and teamwork (ACCT) self-harm monitoring processes alone. There was a lack of collective responsibility, particularly from residential staff and managers, for safer custody procedures. The quality of ACCT documents was variable and lacked consistency. Case management and quality assurance processes were underdeveloped, but we observed some engagement and evidence that prisoners were appropriately cared for."

27. Each prison in England and Wales has an Independent Monitoring Board (IMB) responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. In an extract from their 2009-2010 Annual Report, the Independent Monitoring Board commented that:

> "Overall we have no major concerns as far as this particular prison is concerned this year. Despite the volatile nature of the population and the never ending pressures on the staff, we feel that the overall atmosphere in the prison is calmer. We recognise the generally high standards of the staff in dealing with the daily problems. We hope that staff morale can remain strong as financial pressure inevitably bites. We appreciate the openness of the Senior Management Team which helps us to function properly."

B wing (where the man was located)

28. B wing holds 72 young adults on three landings. The majority of the cells are single occupancy, hence why the man was in a single cell at the time of his death. It is a healthy living unit offering educational work, smoking cessation, acupuncture and stress, alcohol, drug awareness. The wing works very closely with the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) in treating substance misuse.

Critical Debrief

29. A critical debrief takes place after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include staff being able to discuss their experiences in a safe and confidential environment and using the briefing as a learning event to try and prevent repeat incidents.

Cut down tools

30. Cut down tools, also known as ligature or fish knives (because of their shape), are designed for safely cutting ligatures and are carried by all officers and healthcare staff who are in contact with prisoners.

Reception

31. A Cell Sharing Risk Assessment (CSRA) is opened by the reception officer who completes the basic details. The form is first handed to the First Night Centre staff where a confidential interview is conducted. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells. While this is primarily for cell sharing it also includes occasions when other space may be shared, for example to accommodate a Listener (a prisoner trained by the Samaritans to offer support).

32. The initial healthcare screen concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.

Roll check

33. The roll check is the physical count of the number of prisoners on each wing with a prison. Roll checks occur on a number of specified occasions during the day and night, and staff must sign that the roll is correct.

Sealed key pouch

34. Operational Support Grades (OSG) are generally on duty during nights, with their duty starting at 8.45pm. OSGs do not have keys to cells but carry a sealed pouch. This contains a cell key which can be only used in emergencies. During the night state, the whole house block is also locked and the OSGs are locked within by the night orderly officer (officer in charge of the prison) who does carry keys. The house block doors can only be opened by the night orderly officer, who will visit (and contact via radio) each houseblock throughout the night to check that everything is okay. OSGs can communicate with others outside of their house by radio or using the telephone in the office.

Suicide and self harm monitoring

35. The Assessment, Care in Custody and Teamwork (ACCT) is the prison service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT 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 (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff believe the risk of harm to be very high, the prisoner may be constantly supervised, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of supervision may be several times an hour or day. Supervision can also take place during the night. As part of the process, a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings. Wherever possible, the prisoner at risk is also included in review meetings.

Safeguarding meetings

36. Stoke Heath holds two safeguarding meetings a month and a quarterly strategic meeting. The purpose of these meetings is to oversee the safeguarding and violence reduction within the establishment, in essence maintaining and ensuring prisoners safety. The meeting aims to make sure that current practices are fit for purpose, safeguarding all prisoners. Case conferences are held at the end of each meeting to identify any individuals that members of the

meeting have concerns about and plans can be put in place to ensure individuals are being looked after in an appropriate way.

Threshold Assessment Grid (TAG)

37. TAG is a mental health assessment which looks at seven factors. These are intentional and unintentional self harm, risk from and to others, survival, psychological and social factors. There are five points on the risk scale from none to very severe. Scoring can range from Nil to 24. The purpose of the assessment is to prioritise a patient's referral to mental health services, either primary or secondary care.

Youth Offender Team (YOT)

38. The Youth Offending Team (YOT) aims to prevent young people from offending, and to reduce re-offending by young people already known to the police and the courts. The team is made up of staff employed by the council to provide youth justice services, and specialists from partner agencies such as the police, education, youth and connexions services, health and probation services and voluntary organisations.

KEY EVENTS

Prior to the man's second custodial sentence at Stoke Heath

39. Following his arrest for burglary, the man was held on remand from 10 September 2009 at HMYOI Stoke Heath. No risks of self harm were identified by prison staff. He was 17 years old at this stage.

40. After appearing at court on 5 October, he returned to Stoke Heath. Suicide and self harm procedures, the Assessment, Care in Custody and Teamwork (ACCT) were opened at this point as he had admitted to a previous self harm attempt, although he refused to discuss the detail of this. Regular monitoring and observations under these procedures were carried out.

41. On 10 October, he was found in his cell slumped to the floor with a ligature around his neck. Following staff intervention, he was resuscitated and taken to the Intensive Treatment Unit at outside hospital. Despite an initial poor prognosis, he made a full recovery and was transferred back to Stoke Heath on 13 October.

42. On his return, his ACCT remained open. He initially remained on constant watch but this was reduced to half-hourly checks from 16 October. Throughout this period there was healthcare involvement in ACCT reviews and the prison doctor assessed him on a regular basis. He had also been referred to the Child and Adolescent Mental Health Service (CAMHS)[3] and was seen on his return to Stoke Heath by CAMHS In-reach mental health nurse and psychiatrist. He was seen by the psychiatrist on 15 October, who completed a full assessment and noted that there were no underlying mental health concerns. He presented as a socially naive and vulnerable young man. The CAMHS nurse was based within the healthcare unit and case discussions took place at least once a week.

43. Because of the man's age, his self harm act was raised with the Children and Young People's Directorate of Shropshire County Council, who informed Stoke on Trent Children's Services. He was appointed a social worker who visited him on 23 October in the prison healthcare unit at Stoke Heath. The man's social worker noted in her contact log that the man spoke very little and had little recollection of the events preceding his hanging attempt. The man said he was not "fussed either way about whether he could have died", saying he was bored and it was something to do. One explanation he gave was that he was missing watching his favourite television programmes. The man had large bald patches on the back of his head, which the Governor later informed the man's social worker was a result of him pulling his hair out and eating it. Having spent two hours with the man, he told his social worker that, on a scale of one to ten of how happy he was, he was ten (very happy).

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[3] CAMHS are part of the National Health Service (NHS) and works to support and help young people and their families. CAMHS specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties.

44. The man's social worker again visited the man in healthcare on 30 October. Staff told her that he was doing reasonably well and his observations had been reduced to hourly. The man did however express the wish to remain in the healthcare unit on his own. He said he was using his time constructively by colouring in his cell and doing some clay work which he was really enjoying.

45. CAMHS continued to regularly meet the man until his release from custody in December 2009. During these regular appointments his behaviour remained the same. He was described as guarded and difficult to engage with, although staff said they did manage to build up some rapport with him.

46. Mental Health In-reach Nurse A was one of the healthcare staff that had a lot of contact with the man whilst he was located in the healthcare in-patient unit. She told my investigators that healthcare staff had tried to engage with him on numerous occasions but he was "very hard to get through to". He had said that he self harmed because he was bored. Clinical Manager Nurse B also recalled the man providing the reason for his self harm attempt as boredom. Staff tried to keep him occupied whilst in the inpatients unit by engaging him in activities such as games, watching television and education activities. Whilst he had difficulty with reading and writing, he did not appear to have any problems with his level of understanding and was able to understand simple processes.

47. The man's social worker attended the man's ACCT reviews on 13, 19 and 24 November. She described him as not opening up at meetings. He engaged better on a one to one basis where he would appear to be much more alert. In the last ACCT meeting on 24 November, he was in a good mood but had refused association (allotted time out of cell to socialise with other prisoners and do other activities such as use the telephones) over the weekend in favour of watching television in his cell.

48. In early December, the man was released from custody and placed in a hostel under an Intensive Supervision Order[4] as instructed by the courts. He absconded from the hostel, which meant that he had breached the terms of his license. He was returned to Stoke Heath on 15 December.

49. On his return, he went through the normal prison reception screening process. He was assessed and staff raised concerns about his general behaviour and manner. In addition, he did not want to talk about his previous serious self harm attempt at Stoke Heath. His reception health screen noted that a medical/psychiatric report was required and that information received from an outside source (it is not stated where or who) noted cannabis use and a previous self harm attempt. The man chose not to discuss this and had poor eye contact when questioned about his previous self harm attempts. He denied having any current thoughts of self harm or suicidal intention. A referral to

[4] Intensive Supervision Orders are the most rigorous non-custodial intervention available for young offenders. It combines unprecedented levels of community-based surveillance with a comprehensive and sustained focus on tackling the factors that contribute to the young person's offending behaviour. It targets the most active repeat young offenders, and those who commit the most serious crimes.

CAMHS was made, ACCT procedures opened and he was admitted to the healthcare wing for observation. He was to be observed every five minutes.

50. Later in the evening, his mood was noted as upbeat, bright and he said he felt better. He was smiling and chatting to staff who recorded that he had no current thoughts of self harm. He said he had run away from his placement as they would not allow him to have a television, something he now had in his cell. His observations were later reduced to every 15 minutes.

51. At interview, the chair of the IMB told the investigators that it was part of the IMB's role to visit prisoners who were subject to open ACCT procedures. This was especially pertinent to a young person who was located in the healthcare unit as the man was. The IMB's role was to ensure prison processes were being applied correctly and to check on prisoners' well being.

52. As such, the chair of the IMB and other members of the IMB had visited the man in hospital following his self harm attempt and on numerous occasions in the prison healthcare unit. She had a number of one to one conversations with the man, which included her attending his ACCT review meetings. She described him as quiet and not showing any emotion. It was normal for him to provide one word or very short answers to questions asked. He would not talk about his suicide attempt.

53. The man's social worker attended his ACCT review on 17 December. He appeared fine and said he had wanted to come back into prison as he liked it. He was told that as part of his careplan, he would be integrated back to a normal residential wing as soon as possible. Staff were aware that the television was his main focus and he was told that if he refused to engage with the regime he would lose his television for that period, as it was important for him to engage in a programme where he socialised and gained the benefits the prison regime had to offer.

54. Following the prison doctor's assessment, he was later discharged from healthcare on 22 December. He was moved on to a normal residential wing. Four days later, on 26 December, although awake, the man failed to respond to staff when they were carrying out a routine check of his cell. When questioned why, he said he could not be bothered and appeared confused. With staff concerned about his welfare, he was admitted back again to the healthcare unit where his general manner again gave staff cause for concern. As a result, an emergency ACCT review was held that afternoon.

55. At the review meeting, the man reassured staff that he would not harm himself. He said he had had issues with some other prisoners on the wing. He was guarded with his responses and made poor eye contact. An action plan was put together by staff which included trying to alleviate his boredom by encouraging him to attend association and the gym. He was later observed with no problems occurring.

56. He was discharged from healthcare and returned to the wing on 29 December. On 2 January 2010, he was found by prison staff to have self harmed by making superficial cuts to his arm. He was admitted to the healthcare unit and placed in a CCTV monitored cell, being observed every 15 minutes.

57. Having been moved to healthcare, the man began to bang his cell door, covered the CCTV camera and broke a cup. As a result, the Governor ordered that his television be removed from the cell. His disruptive behaviour continued intermittently over the next day where he stuffed paper in the electrical sockets, removed the filling from a duvet and kicked the cell door.

58. On 4 January, at his regular session with the CAMHS worker, it was noted that the man was not interacting and said he was bored. An IQ test[5] was requested. Following a review of his health needs, he returned to a residential wing on 5 January. It was noted that it was hoped he would engage with a full prison regime, attend gym and education.

59. He attended a court hearing on 18 January. He returned later that day and staff noted no concerns. During the evening however, he was again admitted to healthcare unit. Staff had found a ligature that he had made in his cell and he was displaying signs of being upset. With the ACCT document still open, he was placed on 15 minute observations. His mood much improved the following day and he was discharged back to the wing with observations reduced to hourly.

60. On 19 January, the clinical psychologist wrote to the Head of Forensic Psychology informing them that they (the clinical psychologist) was leaving the CAMHS. As such they would be unable to complete the cognitive function assessment[6]. This was felt to be a priority, although a separate psychological report, requested by Stoke Youth Offending Team (YOT) in relation to court proceedings, was to be carried out.

61. A remand review meeting took place on 10 February. The man's social worker attended, as did his parents. The man's social worker reported that it was a positive meeting, and that the man was doing well, was talkative and engaging in regime activities including education.

62. On 22 March, the man returned to court and was sentenced to four months imprisonment. No issues were raised on his return to custody. Two days later, staff observed that he had superficial scratches to his neck. The man said he did not know how this had happened. His mood appeared bright and he denied having any current issues or concerns.

[5] An intelligence quotient, or IQ, is a score derived from one of several different standardised tests designed to assess intelligence.

[6] Cognitive function is the ability of a person to process thoughts. Cognition basically refers to memory, speech, reading comprehension and ability to learn something new. A cognitive assessment is a test administered by a mental health professional, or an educationist to determine an individual's level of cognitive function.

63. The psychological report was completed and received by the prison on 23 March. It detailed his cognitive function, in particular his poor reading and vocabulary. During this consultation with the psychologist, he had displayed his usual lack of communication. He gave some insight to his previous serious self harm attempt, which appeared to have been triggered by an incident in which he was castigated by other offenders for sitting in the wrong chair. This suggested that his self esteem was very fragile and it did not take much to "push him over the edge". The report concluded that his risk of self harm was high, he had a history of reacting impulsively to relatively minor but hurtful events, and lacked regard for his own life. His emotional flatness and tendency to mask his feeling would make it difficult for others to know he was suicidal. There would be a sense of unpredictability which would cause significant problems for those involved in his welfare and management.

64. Following a change in responsibilities, the man was seen by a different social worker on 12 April. It was a short meeting as the man did not want to engage, saying that he had no problems on the wing.

65. The man went to education on a daily basis and was placed in the Nurture Group which, rather than focusing on academic learning, concentrated on social interaction. He also undertook the Toe to Toe programme which takes learning right back to basic issues. He appeared to have benefited from this as staff noted a marked improvement in his confidence, self esteem and the way he presented himself.

66. The man's ACCT document was closed on 15 April. He was reviewed on 18 April by the CAMHS Consultant Psychiatrist who noted that he may carry out impulsive acts of self harm, but that these could not be predicted.

67. A further act of potential self harm (scratching at his tattoos) was identified by wing staff on 5 May. The CAMHS Consultant Psychiatrist examined the man on 6 May. It was noted that he was bright with no concerns, but did not want to access help, and it would be hard for anyone to prevent or predict his acts of self harm or suicidal attempts. He said he was happy, enjoyed association and watching television in his cell. He said when he was released from prison later that month, he intended to live with his mother.

The man's release from custody and period in the community (May – September 2010)

68. When the man was released from Stoke Heath, he was met by his Youth Offending Team (YOT) officer and his mother. He had been placed under specific licence conditions which related to his behaviour and re-offending. His YOT officer described him as being in a "very positive mood", stating that he no longer wanted to get into trouble. Throughout the next three months, he met regularly with his YOT officer who supported him in addressing his offending behaviour.

69. A risk forum meeting was held on 3 June at the Stoke Youth Offending office. It was confirmed that he was complying well and keeping his appointments. His YOT officer had continued to work with him to improve his literacy and

numeracy. It was noted that he had learning difficulties not mental health concerns. Social Care was sporadically involved whenever there was a crisis at his home. He continued to live at home with his parents. He was settled at this address although it was noted the family home was too small for a family of their size. He had not re-offended or self harmed.

70. A further risk forum meeting was held on 17 June. The man was said to be still fully engaging with activities set for him by the YOT. He was still living with his parents and had not self harmed. There had been no recent reported periods of sadness and he appeared more assertive and confident. It was agreed that YOT staff would continue persevering with addressing his educational and training needs.

71. On 24 June, the man attended a substance misuse assessment arranged by the YOT. He said that he was still smoking about ten cigarettes per day. He had given up when he was last in custody but started to smoke again because it was what he did when he was stressed. He was given advice to help him stop smoking. He had not drunk any alcohol or smoked cannabis (or any other drugs) since his release from prison because he said he wanted to stay away from prison.

72. At the risk forum held on 15 July, it was noted that he was doing well. His licence was due to end soon (20 July) and he had not offended or been arrested for the duration of the licence period. He said he was looking forward to this and his YOT officer reminded him that she would still keep in contact with him and support him on a voluntary basis.

The man's return to prison custody

73. Having initially maintained good behaviour, the man appeared before North Staffordshire Magistrates' Court on 24 September 2010 after pleading guilty to an offence of Attempted Burglary on 21 September. He also had further matters pending at Crown Court in regards to offences of Grievous Bodily Harm and Theft. The court was adjourned in order for a Probation Pre-Sentence Report to be prepared.

74. The man was remanded to HMYOI Brinsford. As is normal procedure, he went through the prison reception screening process. His previous self harm was identified. It was noted that he had attempted to hang himself during his first custodial sentence and currently appeared relaxed, accepting his present situation. He said he had no current suicide or self harm thoughts. He disclosed that he used cannabis on a recreational basis and had no mental health issues. A secondary screening (undertaken to capture a person's full medical history) was completed the next day and no further concerns were raised.

75. On 30 September, he moved to a normal residential wing. When his cell was unlocked for evening association, he was found to have barricaded himself in, using cell furniture. Staff spoke with him for 40 minutes with no success try to get him to come out of his cell. The cell door was eventually forced open and

he was moved to the Intensive Assessment Unit (IAU). A ligature was also found in his cell. A referral to the Primary Mental Health Team was made. He was seen by the mental health team and it was noted he was low in mood and refused to give any further details about his situation to staff. An ACCT was opened with staff required to have five conversations with him per hour and observe him hourly during the night.

76. The following day, an ACCT assessment was conducted. It noted that his mood was very low. He talked about his previous cutting attempts and that he had been actively considering suicide for five months, although he had no current intention of harming himself. He said that he expected to get a long sentence following his recent offence and was stressed about this.

77. The next day, his mood was described by staff as “happier”, although he was not very talkative. He explained that the reason why he had had thoughts of harming himself was because during his first week of custody, he had too much time on his hands thinking about the length of sentence he might receive. He assured staff that he would not self harm and would alert staff if this feeling changed. A caremap was setup which included reminding him of the services of Listeners, arranging for him to attend education and helping him gain employment.

78. Following an ACCT review it was decided that the IAU was not the right environment for the man. He had displayed much more settled behaviour since the incident of barricading his cell (on 30 September) and had assured staff at the review that he was okay and had no self harm thoughts. He was returned to the residential wing that afternoon to a double cell. Later that day, staff said he appeared “relaxed and calm and stated that he feels happier now that he has a padmate [cellmate]”. His ACCT remained open and a mental health referral was made. He also began attending educational classes.

79. At an ACCT review the following week, it was noted that he again said he had no current thoughts of harming himself. He was still attending education in the afternoons and staff had put applications in for him to work during the mornings. He said that he no longer got on with his cell mate and expressed a desire to be moved to a single cell. Staff said they would arrange this as soon as possible.

80. No concerns were raised in his ACCT review on 19 October. It was noted that he was doing well in his education classes. Staff, aware that he had a court date on 1 November, kept the ACCT open. At the review on 26 October, he again said he was okay. He was told that it was likely he would be transferred to Stoke Heath following his court appearance. He had no issues with this, but did tell staff that he could not guarantee that he would not self harm. His ACCT remained opened.

81. On 25 October, a mental health assessment was carried out. The assessor noted that he was well presented, a little guarded and slow to reply but communicated answers appropriately. They noted some odd smiling and eye movement. He said that he harmed himself because he got bored and stressed easily. He also said he had never self harmed or had suicidal ideation when in the community, which is contrary to what he told the ACCT assessor earlier in

the month. The mental health nurse said that he would be put on their caseload to develop a therapeutic relationship with him.

82. It is not clear why the man's court appearance scheduled for 1 November did not take place until 12 November. He was however interviewed by a probation officer of the Staffordshire and West Midlands Probation Trust to assist with compiling a Pre-Sentence Report.

83. The mental healthcare nurse contacted the Stoke Youth Offending Team on 2 November. They had concerns regarding his ability to communicate and related difficulties in undertaking an accurate assessment. They were also aware of his previous serious self harm attempt at Stoke Heath. The YOT said that he was no longer on their caseload as he was now over 18 years of age and considered an adult. (The man became 18 on 3 August and his paperwork was handed over to the Stoke office of the Staffordshire and West Midlands Probation Trust.) They gave further information to the nurse by providing the context around his previous self harm incident at Stoke Heath, the seriousness of this and the outcome of the subsequent mental health assessments. It was considered that there was a clear heightened risk of similar behaviour occurring in context of his return to custody. Wanting to try and support him, the YOT had made arrangements with a Learning Difficulty and Psychology Team in the community, but he never attended the arranged sessions. CAMHS in Stoke had deemed him not to be suffering from any mental illness.

84. He was later reviewed by the mental health and ACCT teams. He said he had received a letter from his solicitor which stated that he could expect a sentence of 15 months rather than the four years that he had previously thought, and his trial was to start soon. He was relaxed and talkative with no thoughts of self harm. He had not maintained contact with his family although they had written to him.

85. The man's Pre-Sentence Report written by the probation officer and dated 3 November, made reference to the man's upbringing, his educational, social and emotional needs and his offending history. Within the conclusion of the report, which was submitted to the Court, the probation officer noted:

- "Prison personnel are aware of his current vulnerable status and high potential for suicide. Whilst a custodial sentence would serve to punish the man in the short term it would not serve to address the long term underlying causes of his offending behaviour"

- "It is clear that the man has complex needs for which he had previously undergone psychological assessment. During the course of the man's offending history it has been identified that he has significant cognitive functioning and emotional deficits that underpin his behaviour and as a consequence pose a high likelihood of re-offending. It is concerning that together with little regard for the value of his own life he is unable to appreciate the impact has upon his victims, particular given the escalation in aggressive and violent behaviour as demonstrated in this case. It is clear that if the man's level of harm and likelihood of re-

offending is to be reduced he will require a high level of specific intervention that has as yet not been identified."

86. Having been monitored under suicide and self harm procedures since 30 September, the man's ACCT was closed on 10 November. He said he was settled on the wing, got on with his new cell mate and had no thoughts of self harm. At this time, staff were still not aware of when his next court date would be and a decision was taken to close the ACCT pending further information.

The man's arrival at HMYOI Stoke Heath

87. On 12 November, the man attended court. He was sentenced to serve 20 months in custody and, and as expected, transferred to HMYOI Stoke Heath arriving at around 5.00pm that evening. He was seen by prison reception officers who carried out the initial reception screening process and no concerns were raised. His Cell Sharing Risk Assessment (CSRA) was rated at standard risk which meant he poised no risk to sharing a cell with another prisoner.

88. Healthcare Assistant (HCA) told the investigators that she was on duty in reception when the man arrived. She recognised him straightaway from his previous time at Stoke Heath and that he had tried to harm himself. She confirmed this when reviewing his paperwork. This also highlighted that he had recently been on an open ACCT which was closed on 10 November. Other than that, there were no concerns about his physical health.

89. During her interview with the man, the HCA said that he presented himself well and was in a good mood. His eye and body language was good and he denied having any thoughts of self harm. It was normal procedure for prisoners who were identified with any past history of self-harm, low in mood, or any other concerns about their presentation or behaviour, that an automatic referral to see mental health team would be completed. The man was informed of this.

90. The mental health referral was made by completing a standard template form. This was in line with the mental health pathway, and is called an initial Threshold Assessment Grid (TAG). It is completed to establish the level of priority for a prisoner to be seen for a mental health assessment ranging from 24, 48 or 72 hours to two weeks, which is noted as a routine referral. Depending on the score an appointment would be made within these time frames. The scoring ranged from 0 – 5. The man scored as "0" and was designated as a routine referral for him to be seen within a period of two weeks.

91. Before the man was taken to E wing, the first night wing, the HCA telephoned staff to inform them of his return to custody. She also noted on his CSRA that he had no suicide or self harm thoughts.

92. The man's TAG assessment was reviewed the following day by two mental health Nurses, C and B. A note was added to this that the man should be seen within two weeks. Nurse B told the investigators that this risk assessment was based on how the man presented himself at the time and details would be entered onto their system so that staff could prioritise his referral.

93. The man's prison induction continued over the next few days. He saw a number of different staff, who all explained to him the various programmes and facilities the prison had to offer. Staff also carried out an immediate needs assessment. It was noted that he had difficulties reading and writing and was coping well.

94. On the morning of 16 November, the man's personal officer introduced himself to the man. It was noted on prison records that the man said he had settled on the wing. The man's personal officer reminded him that if he had any issues or concerns he should raise it with staff. The man had no issues to report but expressed a preference to be located to B wing when his induction had been completed.

Opening of ACCT procedures on 16/17 November

95. Later that night (16 November), the man refused to respond to night staff when his cell was checked. Healthcare was informed and visited the man on the wing shortly after midnight (17November). Nurse D spoke with the man through the observation panel on the cell door. The man said he was bored and would not place emphasis on any particular issue. He had no problems on the wing, and communicated well with the doctor. He was offered access to the Samaritans and a newspaper to alleviate his boredom. He refused both and said he wanted to go to sleep. Due to his previous self harm attempt at Stoke Heath, ACCT procedures were opened as a precautionary step. Staff were to monitor, observe and make five entries per day in the ACCT record as well as ad hoc patrol checks to ensure his well being.

96. An ACCT assessment interview took place the following morning around 9.00am. It was recorded that the man was easily bored which made him stressed. He had no problems on the wing and was not being bullied. His only problem was boredom. He said his brother and other friends were located on B wing and a move to be with them would reduce his boredom. He had also made superficial cuts to his right forearm at around 10.00pm the previous night. He told the assessor that it was only a few scratches and was not a serious attempt to harm himself. He had found that there was nothing on television and felt bored which led him to be stressed. He said these feelings were worse at night. He was not depressed but felt tired and did not want to come out of his cell.

97. As the assessment interview continued the man appeared to become uncomfortable, although he said initially that he did not mind discussing his acts of self harm. Towards the end of assessment, he indicated he was becoming stressed. His previous suicide attempt was noted but he said he could not remember much about it and was unsure why he did it. At that time he said he wanted to die but did not want to now. Although he currently did not feel suicidal he felt he would cut himself (tonight) if he again became bored and stressed. The man said he would not discuss these feelings with anyone if he had them and would not tell staff if he intended to self harm. He expressed his unhappiness at being on the ACCT procedures and intended not to attend reviews or speak to the prison chaplain. He had however received letters from

his mum and brother. Although his mother used to visit him in the past in prison, the man had not sent out a visiting order recently, saying he "can't be bothered". He identified music as a possible stress reliever and said he wanted to take part in education. He also said that his brother (on B wing) self harmed by cutting. He was told that a further review would be carried out by wing staff and he was told to contact staff should he have any feelings of wanting to self harm. Some of the actions to be taken and recorded on his careplan, were to constructively occupy his time and a move to B wing.

98. Wing staff interviewed the man at 10.00am for his first ACCT review. He said he had no current thoughts of self harm and was reminded about the support mechanisms available. He was reluctant to fully engage with the review and did not want to speak. It was therefore decided that the ACCT should remain open.

99. The man's next ACCT review took place on 19 November. The wing senior officer (SO) and his personal officer were present. Although the SO tried to persuade him of the benefits of having a member of the healthcare team present, he (the man) was adamant that no one should attend. When discussing his self harm episodes, he told the review team that it was his way of coping with stress and that he felt much better afterwards. He also felt embarrassed to tell staff this. The SO offered reassurance to him that the staff would always offer assistance in these situations. The man said he hoped to be released on a Home Detention Curfew Licence in February 2011 and again asked if he could be moved to B wing where his brother was located. The SO maintained that the ACCT should remain open and agreed to chase up his move to B wing.

The man's move to B wing

100. The next ACCT review took place on the morning of 24 November held again by the SO and personal officer. Again it was a non multi disciplinary review meeting at his request. He said he was okay and noted that staff were making efforts to keep him occupied. He denied having any thoughts of self harm or suicide. When told that he would be moving to B wing later that day, he appeared very happy.

101. Around 10.10am, the man was moved to B wing. Officer A was assigned as his personal officer and met and introduced himself to the man in the afternoon. The officer told the investigators that the man said he was happy to be on B wing and reunited with his brother. B wing is predominantly a single cell wing but does contain four double cells. He was asked if he wanted to share a cell however said he preferred his own space. Although he was currently subject to the ACCT procedures, he told the officer that he hoped it would be closed soon and that he had no current issues or concerns. This was recorded on the prison computer system (NOMIS).

102. The man's next ACCT review was carried out on 2 December. Two officers (one of whom was his personal officer) and the wing SO attended. It was noted that he got stressed when a lot of people attended the review meetings. As for

his present status, the man had been on B wing now for over a week. Staff had reported that he socialised with his brother during association and appeared to get on well. He was attending the gym and mixing on association with friends he had on the wing. It was noted that his care map and triggers relating to self harm were both reviewed. The decision was taken to close the man's ACCT.

103. On 3 December, the second part of the TAG assessment was completed by Registered Mental Health Nurse (RMN) E. She carried out the interview for the TAG assessment on B wing. Although the man said he was fine, he did not want to fully participate with the assessment. The nurse said that he continually kept asking if he could return to his cell to watch television. His mood seemed okay, he engaged and no concerns had been raised by the wing staff. The man's TAG score remained at nil with no problems identified. The nurse said the rationale behind the man's TAG score was that he had not recently self harmed, was considered settled and had no current self harm ideations. She had known him from his previous period in custody at Stoke Heath and was fully aware of his suicide attempt. A note to this effect was made on the TAG document. As a result of his appropriate behaviour, no further referral to the Mental Health In-Reach team was made. Instead, he was to remain on the case load of the primary care nurses.

104. On 4 December, around 9.30pm, Registered General Nurse E was called by the night operational support grade officer (OSG) to attend B wing. Whilst checking the outgoing mail, the OSG had come across a letter written by the man. The letter was addressed to his girlfriend and indicated his thoughts of self harm. The man had said goodbye in the letter and intimated that he would not be here for Christmas. The nurse arranged for the man's cell to be unlocked so she could speak and assess him. The man was smiling. He said he only wanted to worry his girlfriend and had no intention of harming himself. The nurse sat and spoke with him for a while and offered him reassurance and support. Although considered by the nurse, the man did not want to be moved to the healthcare unit. An ACCT was opened and he was placed on 30 minute observations.

105. The following morning, on 5 December at 9.30am, an ACCT assessment was conducted by Officer B. He had also known the man from his previous period in custody. The man said he remembered Officer B from the hospital after he (the man) had attempted to take his life the previous year.

106. Officer B explained to the man the purpose of the ACCT procedures and why they had been initiated. When he talked about the letter that the man had written, the man started to laugh. He said he had no intentions to take his life and the contents of the letter were just a joke. Officer B probed him further as to how he was feeling about letter, however the man was "adamant" that it was all a joke and he had wanted to "wind up the night officer" on duty.

107. Officer B told the man that staff were concerned about him, especially given that he had made a previous serious suicide attempt. His mood appeared "bright" and he said he did not want to be on an ACCT. The man said he would act in an adult manner in future and would not make rash statements about

self-harm, suicidal thoughts or intentions. After Officer B had completed his assessment, he passed the documentation onto the case manager to decide the next steps.

108. Immediately after the assessment, at 10.00am, the first ACCT review meeting was held. SO A was the case manager and he was assisted by two B wing officers. Nurse A and Officer B were consulted to gain their input. As well as the man, his brother also attended the review. The man said he was adamant that he was only messing around and wanted the ACCT to be closed. He did not like the fact that staff were always checking up on him. He was offered the Samaritans phone and reminded of other support services available. The man's brother believed that his brother was okay and along with the agreement of the nurse and officer, the ACCT was to remain open, but with observations reduced to hourly.

109. Following ACCT reviews on 6 and 10 December, the ACCT was closed on 10 December. Nurse A, Officer C and SO B were present at the last review, which noted that the man's eye contact and posture were good and he was now in employment working on the recycle party. He told staff that his relationship with his girlfriend had broken down, but they remained friends and he was okay. SO B told the investigator that the man refused the offer of the prison chaplain attending the review. He said he was happy on the wing and happy in a single cell, preferring not to share with his brother. He said he had no intention to hurt himself and requested to be taken off ACCT procedures. The SO felt that enough relevant support mechanisms were in place for the man to enable the ACCT to be closed. This included knowing that a post closure review would be undertaken in seven days time.

110. Over the next few days, there were only a few entries made on NOMIS about his behaviour. He had refused to work on a couple of occasions, although there were no concerns noted that he might self harm. (An entry made on 17 December said "the man works well when he is here, however refused to work on Thursday".)

111. On 17 December (noted on ACCT as17/10/2010), the ACCT post closure interview was conducted by SO C and Officer C. Prior to meeting with the man, the SO spoke with wing staff and extracted information from NOMIS to find out as much background as possible about the man. During the meeting, the SO said he went through the ACCT process and why it had been originally opened. The man said and reiterated that his comments in the letter to his girlfriend were not serious and he was fine. The SO reminded the man of the support mechanisms that were in place and acknowledged that the man had good support from his brother and staff on the wing. The meeting lasted about 15 minutes and his presentation throughout gave the SO no concerns.

112. Prior to Sunday 19 December, the man had made five telephone calls to his girlfriend between 2 December and 16 December. The content of these calls showed their relationship was quite volatile at that time. In their conversation on 2 December, he made reference to being in possession of a razor blade. Although the man alluded to harming himself, he told his girlfriend that "I don't

feel like it". He made two telephone calls to his girlfriend on 16 December at 7.24pm and 7.46pm. The conversation mainly revolved around an allegation that his girlfriend was in a relationship with someone else, something which she denied. Their relationship appeared to have broken down at this point.

113. The man made his last telephone call to his girlfriend again on Sunday 19 December at 2.47pm. They talked about his release from prison which he said could be in about a month's time. He said he would ring her back on Wednesday (22 December).

114. Soon after the man had spoken with his girlfriend, at around 4.45pm, SO A had a brief conversation with him whilst he (the man) was carrying out his recycling job outside. The man's mood seemed okay and he was smiling. SO A believed the man's general demeanour had improved a lot since he first arrived on the wing. He was coming out of his cell a lot more and was mixing and talking more to other prisoners. As a senior manager, SO A said that all the SOs frequently discussed the man and agreed that he was doing well and that they were pleased with the progress he had made.

Events on Monday 20 December 2010

115. Officer D began his shift at 7.30am that day. As a B wing officer, he had frequent contact with the man. He was aware of the man's past self harm history but he had no concerns about his general demeanour or how he interacted with staff or his peers on the wing.

116. On this particular day, Officer D did not recall having much interaction with the man. After the normal day's routine of prisoners attending workshops, education and other appointments, they have their evening dinner between 4.30pm and 5.10pm. Following this, all prisoners are locked in their cell until the evening wing association. The wing association is split into two sessions and runs from either 6.00pm to 7.00pm or 7.00pm to 8.00pm. After they are unlocked, prisoners make their way downstairs to the main association room or possibly to one of the other designated areas to play pool, watch television or use the telephones. After each respective association period, prisoners are locked back into their cells for the night.

117. Officer D confirmed that the man's association period was at 7.00pm to 8.00pm. During this, he recalled the man just mingling amongst his peers and playing table football before returning to his cell at 8.00pm.

118. Officer D carried out the roll check on the man's landing about 8.05pm. On checking the man's cell he looked through the cell observation flap. The man appeared to be okay and responded accordingly to the officer. The officer finished duty at 8.15pm. Between 8.15pm and 9.00pm Officer E was the only officer on duty on the wing.

119. Officer E told the investigators that he was on duty on the evening in December. Although he had not been assigned to carry out the roll check on the man's landing, he recalled seeing him during association period. After the

roll check was completed, he also checked that each cell door was secured properly which took about ten minutes to complete. This check does not include a visual check of prisoners unless they were on an ACCT document. There were however no open ACCTs on the wing that day. At around 8.45pm, the officer conducted a handover to the night duty officer, Operational Support Grade (OSG) A, before his shift ended. He regarded the evening as being quiet, with no cell bells being activated.

120. OSG A worked permanent night shifts. She had had no first aid training. The OSG told the investigators that her duty began at 8.45pm by carrying out the wing roll check. She would check all the open ACCT documents and confirm what checks she was expected to do throughout the night. In addition, her role consisted of doing the night pegging duty, which was a patrol of alternate wing landings every 20 minutes, which was recorded by an electronic pad on the respective landing. Occupants of cells are not checked during the pegging process unless they are on an ACCT, or if they have pressed their cell bell to seek assistance from staff. The morning roll check would then be carried out at about 6.30am the next day.

121. When OSG A arrived on B wing, she said that Officer E conducted a handover. He told her it had been a quiet day with no issues to report. She went upstairs and began her roll check of the wing from the "3s" landing (this is in fact the second floor; the ground floor is known as the "1s landing"). When she arrived at the man's cell (on the 3s landing), she opened the observation flap and saw him with a ligature tied from the top of the window and placed around his neck. His feet and knees were touching the floor and he was facing the window with his neck lowered.

122. OSG A used her radio and called "urgent assistance, I have a Code Blue" (this emergency code indicates that a prisoner is experiencing breathing difficulties). This is recorded on the prison incident log as occurring at 8.54pm. She broke the seal on her key pouch and radioed through again and gave the number of the cell (65) and that assistance was required. As the OSG put her key in the cell door, Senior Officers E and F arrived on the landing. SO E took over and opened the door and entered the cell. The OSG also used her radio to contact the healthcare unit.

123. SO F was the orderly officer (the officer in charge of the prison) on the evening duty. At around 8.45pm he carried out his handover of duties to the night orderly officer, SO E, in the communication room. At around 8.55pm, they both heard OSG A's Code Blue call for urgent assistance transmitted over the radio network. The two SOs made their way to B wing straightaway, taking between one and one and a half minutes to arrive. En route, they passed a number of officers, including Officer E, who were about to leave the prison having finished their evening duty. They returned to the wing to offer assistance.

124. When SOs F and E arrived at the man's cell, OSG A had already broken the seal on her key pouch and her key was in the door. SO E looked through the cell door observation panel and saw the man hanging from the window at the back of the cell. The ligature was made out of a thin green bedding sheet

which had been cut and tied to the top of the window frame and around the man's neck. He was on his knees leaning forward "taking the weight".

125. SO E had not received any recent first aid training. Having unlocked and entered the cell he lifted the man's body weight whilst SO F used his cut down tool to cut the ligature. The man did not respond to staff and was described as a blue grey colour with his tongue protruding from his mouth. SO E used his radio to also call for healthcare and the first response team to attend B wing. Following this he left the cell and began to co-ordinate staff activities. This included ensuring a log keeper was appointed to record the names of those who entered the man's cell. He also called for an ambulance which was recorded on the incident log as occurring at 9.00pm.

126. When Officer E arrived at the man's cell, the door was already open and the man was lying on his side on the floor. Officer E called the man's name but gained no response. Officer E was first aid trained. He checked the man for any visible signs of life by checking his breathing and pulse, but did not find any. The officer also noticed that the man's face was blue. Assisted by SO F (who was also not first aid trained) and Officer F (who had returned to the cell with Officer E), they moved the man onto his back to start cardio pulmonary resuscitation (CPR). Having placed a face hygiene mask on (most officers at Stoke Heath carry them), SO F commenced two rescue breaths whilst Officer E started to do 30 chest compressions. Officer E said he recalled that somebody outside of the cell had asked if there was anybody present that was first aid trained, but he did not believe there was.

127. Registered General Nurse F was about to conclude her shift for the day when she heard over her radio that healthcare were needed for an emergency on B wing. She returned straightaway to the healthcare wing and along with the night duty nurse, Nurse E, they collected the red and blue emergency bags (basic medical equipment and emergency medical equipment) and defibrillator machine[7]. An officer had been sent to meet the nurses and unlocked the gates en-route to B wing to get them there as quick as possible. Nurse F said they were at the man's cell in just a few minutes of hearing the alarm

128. As Nurse F entered the cell, she observed two officers carrying out CPR on the man. On the prison incident log, it is recorded that healthcare arrived at 9.00pm. Nurse F immediately took over chest compressions from Officer E and Nurse E took control of the man's airway. The man still showed no signs of life. Nurses G and A arrived right behind the first two nurses with more equipment and they all worked together to carry out chest compressions.

129. Nurse G said that the man was lying on the floor fully clothed with his head towards the cell door. His eyes and mouth were open, he appeared not to be breathing and was cyanosed (blue in colour).

[7] Defibrillator is a life saving machine that gives the heart an electric shock in some cases of cardiac arrest.

130. Nurse F cannulated[8] the man's arms in preparation for fluids to be given to him. Nurse G continually assisted the two nurses in the cell by passing them medical equipment and fluids (sodium chloride) as and when needed. The man's clothes were also removed so that the defibrillator pads could be attached. The defibrillator however continually instructed that CPR should continue. Nurse G said the nurses were doing everything they could to save the man's life.

131. The paramedics arrived at the prison at 9.10pm and arrived at the man's cell at 9.15pm. They were briefed and immediately set about administering adrenalin through the prepared cannulated arm. Nurse G timed this as being administered at 9.15pm. The paramedics then took over the man's care from the nurses and used their equipment to monitor and try to revive him. They managed to find a pulse and immediately prepared the man to be escorted to the ambulance and taken to the accident and emergency unit at Princess Royal Hospital, Telford.

132. SO E arranged for two prison officer grade staff to act as escorts for the man to the hospital. The ambulance left the prison at 9.44pm. The escort log recorded that no restraints were used. He also contacted the duty governor at home to inform him of the evening's events. SO F held a short briefing meeting in the boardroom with those staff that responded to the emergency. The staff care team services were offered to all staff. OSG A was relieved of her night duty as she was still quite visibly shaken.

After the man was taken to outside hospital

133. As soon as the man was taken to outside hospital, prison staff spoke with a number of prisoners on the wing offering support. It was not known how serious the man's injuries were, but staff were aware they were life threatening. SO F also held a short hot debrief (a meeting conducted after a serious incident to review the events that occurred) meeting at 10.00pm in the boardroom to speak with staff who attended his cell that evening and to offer support.

134. When the duty governor arrived at the establishment later that night, he accompanied SO E to the man's brother cell. They told him of the man's suicide attempt.

135. Afterwards, and throughout the night, SO E and the duty governor tried to contact the man's mother to let her know what had happened. This proved difficult as there was no answer from the telephone number recorded on the man's next of kin records. After several attempts, SO E went to see the man's brother, who provided a few more contact telephone numbers (and included the number SO E had previously tried), but this too proved unsuccessful.

136. The duty governor offered support to all those staff involved with attending the man's cell. He also reminded them to make written statements about the events that occurred. As there was still no response to SO E's calls to the

[8] A canula is a tube that can be inserted into the body, often for the delivery or removal of fluid.

man's next of kin, the duty governor decided to contact their local police. He followed this up by faxing them the man's details and what had occurred. The police agreed to try and locate the man's mother. The man's mother was later found and she telephoned the prison shortly after 5.15am. Arrangements were made for the hospital to contact her to explain the man's current condition. The prison subsequently arranged transportation to take the man's family to and from hospital over the forthcoming days.

Tuesday 21 December / Wednesday 22 December

137. Governor B arrived on duty to be informed of that the man had harmed himself. He immediately spoke with the man's brother (around 8.00am) to check on his well being. As part of the support offered to him, the man's brother was allowed to ring his mother and family.

138. Having returned to duty the following morning, Officer E also spoke to the man's brother to check upon his well being. The man's brother said he had spoken to him during the evening association and he seemed okay. Nurse A also offered continual support to the man's brother. He told the nurse that he had played table tennis with him during association and he appeared okay. He could not understand why he had harmed himself as he had been given a lot of support from staff.

139. Healthcare contacted the hospital to check on the man. He remained in the High Dependency Unit in a critical state on a ventilator. He was being monitored hourly. The bedwatch prison escort officers contacted the prison on a regular basis to provide an update on the man's condition. The following morning hospital staff reported that the man's condition was unchanged. The bedwatch prison officers recorded that he was assessed by a doctor at 11.45am and declared clinically brain dead and that further tests would be undertaken in the afternoon. The prison were informed of this and contacted his parents. Transportation was arranged for them to attend the hospital as soon as possible.

140. Following further planned tests that afternoon, the man was pronounced clinically brain dead. The time of death was recorded as 12.35pm. The prison was immediately informed. Governor A attended the hospital with the family. Arrangements were also made for the man's brother to attend the hospital.

After the man's death

141. Governor B invoked the death in custody contingency plans and ensured that all the relevant agencies, including the police, were informed of the man's death. He was also appointed as the Family Liaison Officer (FLO). He telephoned the man's father the next day to arrange initial meeting with him and the rest of the man's family to introduce himself. (This later took place on 31 December.) Over the forthcoming days, Governor B liaised with the police, coroner and funeral directors. The prison offered financial assistance towards the man's funeral.

142. The then Acting Assistant Ombudsman also spoke with the man's brother on 29 December when she opened this investigation. The man's brother confirmed that he had spent the evening association with his brother and that he had no idea that he was thinking of harming himself. He described the man as someone who kept his feelings to himself. He also said that the man had split up with his girlfriend a couple of days before 20 December, but he did not seem bothered even though they spent all their time together outside of prison. The man's brother said that he had been well supported by the prison and had been allowed extra telephone calls to home.

143. The family met with Governor B and prison staff on 31 December in the prison chapel. The man's brother was also present. The prison later held a service in the chapel for him which was well attended. The man's brother was released from custody on 17 January 2011. The man's funeral took place on 20 January.

144. As is expected following a death in custody, a critical debrief is held approximately six weeks after the death. Staff who attended the meeting found it informative and beneficial.

Post mortem report

145. The post mortem examination was carried out. Amongst his findings, the examiner reported the following:

> "The circumstances that are described indicated that this the man hanged himself but he was found and cut down before he died. However by the time that resuscitation was commenced, the brain had been deprived of a blood supply for a sufficient time that irreversible and ultimately fatal changes had occurred in it.
>
> "There are no marks or injuries anywhere on the body to suggest that death had resulted or had been contributed to by any other mechanism, nor are there any marks to suggest that the deceased had been physically assaulted or forcibly restrained in the few hours prior to his death."

Other relevant matters

146. The investigators were provided with the minutes of the first Safeguarding Meeting following the man's death, held on 4 January 2011. There was no mention of the man's death in the minutes.

147. The chair of the IMB, did however provide the investigation team with a copy of the IMB report which was submitted to the Safeguarding meeting in January. It reported the man's death and the brief circumstances surrounding this. It also included the following statistics:

> The number of ACCT's open in December 2010:
>
> YA (Young adult) 14

YP (Young person) 8

12 incidents of self harm in December 2010

ISSUES

Clinical care

148. The clinical reviewer reviewed the man's prison and associated records. He has made three recommendations which I fully endorse and incorporate into my own findings.

Physical health

149. The man had no identified physical health problems. Input from healthcare staff was limited to treating mouth ulcers on one occasion.

Mental health

150. Following the man's suicide attempt in 2009, the risks he posed to himself were well documented. He was and continued to be assessed by an array of professionals all seeking to improve his outlook on life. The man struggled to form and articulate his thoughts and feelings which was demonstrated after this suicide attempt.

151. At the time, the man was still under 18 years of age and therefore was referred to the CAMHS. CAMHS have a wider role than adult mental healthcare services and were able to offer support to him. However, he did not engage well with the service, was uncommunicative and gave very little away about himself and his feelings. He regularly attended the sessions with the CAMHS nurse, and these were productive, especially when he engaged in activities. The man was seen by the CAMHS consultant who noted that he may carry out impulsive acts of self harm but this could not be predicted.

152. When he was sentenced on the second occasion, the man was 18 years old and was no longer eligible for the CAMHS. Secondary care mental health service have a very specific service specification, and only deal with prisoners who have an acute or enduring mental health illness. Having consistently been assessed as not suffering from any depression or mental health illness, he would not have been treated by these services. Primary care provide mental healthcare for conditions which would normally be dealt with by a GP practice in the community, for example depression. His condition did not fall under the categories usually dealt with and treated in a primary care setting.

153. When at Brinsford, the primary care team kept the man on their caseload for a therapeutic relationship and to monitor his behavior, in essence to keep an eye on him. On reception at Stoke Heath, his self harming behavior was identified, and he was referred to mental health. He was assessed but no treatment had commenced prior to his death.

154. In conclusion, although the man was not diagnosed with any mental illness, he was assessed as having communication and learning difficulties, and other significant social problems. It was also thought that with the issues the man had, it would be difficult to address the specific nature of his problems in a

custodial setting. He was generally considered at a high risk of future self harm, the triggers for this were not identifiable and as a result, his self harm incidents were expected to be unpredictable.

155. The clinical reviewer adds that the man had very specific needs in addressing his social and psychological problems as a result of his poor communication problems. Services within the healthcare setting are designed to address physical and mental health needs, but would not address his social problems. Indeed, greater availability of psychological support for prisoners with specific needs may be of benefit. The prison setting would be an ideal environment to try to address these problems. However, given their specialist nature, it is likely to be difficult and challenging to establish what sort of service could be provided.

156. I certainly believe the mental health care intervention the man received was appropriate and make no recommendation on this issue. I do however suggest that the Head of Healthcare considers this report and the Clinical Review as part of their normal review of the mental health support services offered to prisoners.

Threshold Assessment Grid (TAG) assessment

157. After the man was referred to the mental health in-reach team, the initial Threshold Assessment Grid (TAG) was carried out by the HCA on reception duties. This assessment looks at seven factors: intentional and unintentional self harm, risk from and to others, survival, psychological and social. There are five points on the risk scale from none to very severe. Scoring can range from nil to 24. The purpose of the assessment was to prioritise a referral to the mental health services, either primary or secondary care. He scored nil and the planned intervention was to give support to him as required.

158. The TAG is only a prioritisation tool and regardless of the score a person receives, they would still be seen by the mental health team. However, given his history of both serious and minor self harm, the investigation team were more than surprised that the man was scored as “nil”. The HCA who completed the TAG said she was looking at it on the day, not on past history. All assessments that require behaviour to be interpreted will have a degree of subjectivity and as a result assessment scores will vary dependant on who is making the judgment.

159. That said, the Clinical Review panel felt that the Threshold Assessment Grid score should have taken more account of past history of self harm and the prisoner social and psychological factors. The panel accepted that whilst this would have increased the score it would have been unlikely to lead to any substantive treatment and would not have had any impact on the event. It would also take into account of the fact that the man was not suffering from depression or a mental illness and so referral for any significant treatment was not necessary. I do however make the following recommendation.

The Head of Healthcare should ensure healthcare staff achieve more consistency with the TAG assessment process.

Suicide and self harm procedures

160. From his past history of self harm, the man had a tendency to mask his feelings. This made it hard for others to know that he was suicidal thereby creating a sense of unpredictability, and that caused difficulties for his welfare and management. Coupled with this, the man just appeared to lack regard for his own life.

161. Staff were concerned enough about the man to open suicide and self harm procedures on two occasions. The investigation team felt that he was well managed throughout them. When any sign of intention to harm himself was identified, for example the letter written to his girlfriend, an ACCT was introduced. During this process the man gave little information about his reasons for his behavior and he displayed no further concerns.

162. On one occasion however, the man requested that healthcare staff were not to be present for the ACCT reviews. His wishes appear to have been complied with. Whilst there was good evidence that healthcare staff were consulted prior to the reviews, staff completing or leading the review should be aware that healthcare professionals may notice patterns of behavior as a result of their training and experience that could be of great use. It is certainly worthy to note as good practice that the man's brother (who was in custody on the same wing) was involved in the review process with his agreement. I make the following recommendation.

The Governor and Head of Healthcare should remind ACCT reviewers to carefully consider whether healthcare staff presence or input at ACCT reviews would be beneficial, even if this is against the wishes of the prisoner.

Could the man's self harm act have been predicted?

163. It has already been noted that the triggers for the man harming himself were not identifiable and therefore unpredictable. Boredom was certainly a frequent expression he used following an act of self harm. He did, however, appear to be using his time constructively during his last period in custody, and was engaged in education and work activities.

164. Even in the short periods that the man was not on ACCT, staff were naturally aware of his vulnerabilities because of his history of self harm. He had given staff no concerns on the day, prior to being discovered in his cell. Prison officers had had spoken to the man, as did his brother during the association period. None of them had any concerns about his well-being. Prison officers stated that they had been pleased with the progress the man appeared to have made, especially his efforts for the work he was doing on the recycle party during a period of particularly cold weather.

Emergency response

165. The emergency response when the man was discovered was prompt and professional, with healthcare staff arriving extremely quickly after the alarm was raised. The investigation team found that the appropriate actions were taken and no other actions could have been carried out. However, only one member of discipline staff who initially attended the cell had previously received first aid or resuscitation training. I consider it essential that uniformed prison officer staff, who are usually the first responders to medical emergencies, have up to date first aid training which enables them to start CPR. I refer to a letter written by the Chief Executive of NOMS and dated 29 October 2010, to all prison governors. The letter highlights the need for each establishment to review their first aid arrangements for prisoner-related incidents and, where inadequacies are identified, action plans must be put in place with timescales to remedy the situation.

    The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties.

166. The investigation team felt it worthy to note the efficient actions of Nurse F who was one of the first members of healthcare to arrive at the man's cell. She carried out the swift cannulation on both of the man's arms in preparation for fluids to be injected to assist with preserving his life. This allowed the paramedics on arrival to immediately give adrenalin to the man.

Safeguarding Meeting

167. The investigation team was provided with the minutes of the first Safeguarding Meeting following the man's death, held on 4 January. There was unfortunately, no mention of his death in the minutes. The investigator did however review the IMB report submitted to the meeting, which covered the man's self harm act and subsequent death. I think it good practice to ensure such major events as a death in custody is always directly recorded in the Safeguarding Meeting minutes at the appropriate time.

    The Governor should remind staff that all incidents of serious self harm and death should be included in the Safeguarding Meeting minutes.

Contact with the man's family

168. Following the man's death, the contact with the family was dealt with appropriately by prison staff. I would also like to mention that the man's brother, who was located on the same wing, was managed by staff in a very considerate and inclusive manner, at a time which was no doubt difficult for all involved. This included prison staff arranging for the man's brother to visit the hospital at the time of his death.

CONCLUSION

169. The man had a history of self harm and during his custodial periods the suicide and self harm procedures were invoked a number of occasions. He was described by those professionals that assessed him as not placing a value upon his life and, despite various types of support both inside and outside of prison, the man's outlook on life now appears to have remained unchanged. After his first suicidal intention he displayed an apathetic attitude to those in contact with him.

170. The man's self harming was often unpredictable and certainly meant that it would be very difficult for staff to fully be aware what he was thinking. The man's behavior was not necessarily preceded by any immediate signs or symptoms indicating he would want to end his life.

171. During the time that the man was in custody, I do not believe that staff could have acted differently to prevent him taking his life. On more than one occasion, he harmed himself and admitted he had done so out of boredom. I do not underestimate the difficulty of looking after someone with his complex needs in a prison environment. I concur with the CAMHS consultant psychiatrist that it was very difficult to predict when he would next make a suicide attempt.

Recommendations

1. The Head of Healthcare should ensure healthcare staff achieve more consistency with the TAG assessment process.

2. The Governor and Head of Healthcare should remind ACCT reviewers to carefully consider whether healthcare staff presence or input at ACCT reviews would be beneficial, even if this is against the wishes of the prisoner

3. The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties.

4. The Governor should remind staff that all incidents of serious self harm and death should be included in the Safeguarding Meeting minutes.