Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Mulvey, following his release from HMP Wealstun, on 12 February 2019

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Robert Mulvey died on 12 February 2019, after jumping from the eighth floor of the building where he lived following his release from HMP Wealstun four days earlier. He was 32 years old. I offer my condolences to Mr Mulvey's family and friends.

This is a very sad case of a troubled man. Mr Mulvey had serious, long-standing mental health and substance abuse problems. Prison Service staff appropriately started suicide and self-harm prevention procedures two weeks before his release from prison, and several aspects of his management were positive.

However, there were also some basic aspects of the procedures that prison staff did not comply with. And, in view of Mr Mulvey's impending release from prison and his mother's unexpected death a few days beforehand, I am disappointed that his family were not informed of or asked to contribute to the suicide and self-harm prevention procedures.

I am also concerned that, although Mr Mulvey had been prescribed antipsychotic medication for several years, no one at Wealstun or HMP Leeds (where he lived before being transferred to Wealstun) referred him to their mental health teams on his arrival, contrary to national guidelines. There are also some aspects of the discharge arrangements for dual diagnosis prisoners that require review.

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

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

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Summary

Events

1. On 5 December 2018, Mr Robert Mulvey was sentenced to seven months and twelve days in prison. He had been diagnosed with schizophrenia several years earlier and was prescribed antipsychotic medication in the community, although he did not always take it. Mr Mulvey also misused drugs in the community. On arrival at HMP Leeds, he was prescribed methadone (opiate substitute medication) but was not referred to the mental health team and was not prescribed an antipsychotic.

2. On 8 December, Mr Mulvey told an officer that he could hear voices. The officer contacted the mental health team and a mental health nurse assessed Mr Mulvey four days later. She recorded that Mr Mulvey had delusional thoughts but was "not interested" in taking antipsychotics.

3. On 27 December, Mr Mulvey was transferred to HMP Wealstun. No one referred him to the mental health team on his arrival.

4. On 24 January 2019, Mr Mulvey told a prison nurse that voices had told him to harm himself, and that he had poured boiling water on his hand and banged his head on a wall. The nurse started suicide and self-harm procedures, known as ACCT. A prison psychiatrist prescribed antipsychotic medication.

5. The next day, Mr Mulvey cut his wrist. He later told prison staff that this was an attempt to take his life.

6. On 29 January, the psychiatrist reviewed Mr Mulvey and recorded that he was acutely psychotic. Two days later, Mr Mulvey told an ACCT case review that his thoughts of harming himself had reduced considerably. He stopped taking his medication, and said this was because he did not like to take the antipsychotic as a tablet. The psychiatrist prescribed a weekly injection of antipsychotic medication (known as a depot) instead.

7. On 5 February, Mr Mulvey's father telephoned the prison to inform them that Mr Mulvey's mother had died unexpectedly. A chaplain broke the news to Mr Mulvey, and prison staff held an ACCT case review immediately afterwards.

8. On 6 February, Mr Mulvey's application for release on home detention curfew was approved. His release was arranged for 8 February. Prison healthcare staff arranged an appointment for him with the community drug team, and informed Mr Mulvey's community mental health keyworker of his release arrangements. They arranged a methadone prescription for his release and ensured he knew when his next depot injection was due.

9. On 8 February, prison staff held an ACCT case review immediately before Mr Mulvey was released. Mr Mulvey told them he was excited about his release.

10. On 12 February, Mr Mulvey jumped from the eighth floor of the building in which he lived with his father. He died in hospital that evening.

Findings

Managing the risk of suicide and self-harm

11. Prison staff took some positive, supporting actions to help Mr Mulvey, and his ACCT case reviews were multidisciplinary with good input from the mental health team and broadly consistent case management.

12. However, the first case review was held later than national policy stipulates and was not of the quality required. There was also a missed opportunity to involve Mr Mulvey's family in his ACCT plan and care, which would have been particularly helpful given his impending release to live with his father. Mr Mulvey's ACCT case manager should also have led the final case review before his release.

Health provision

13. Although Mr Mulvey had received treatment in the community for mental ill health for several years, he was not referred to prison mental health teams on arrival at either Leeds or Wealstun.

14. Mr Mulvey received appropriate care after he was later referred to the mental health team at Wealstun, although we found that aspects of his release arrangements require review.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
  - Case managers are appointed promptly after ACCT procedures are initiated, and first case reviews are held within 24 hours of the start of ACCT monitoring.
  - ACCT caremap actions are initiated at the first case review, are specific and meaningful, and identify all the issues identified at assessment interviews and case reviews.
  - Case reviews consider all relevant information that affects risk, and only reduce the level of risk when indicated.
  - Case managers lead the final case review before release from prison, whenever possible.
  - Consideration is given to informing and involving the family of the prisoner in the ACCT process, particularly when release from prison is upcoming.
- The Heads of Healthcare at HMP Leeds and HMP Wealstun should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate, and make a referral when indicated.
- The Head of Healthcare at HMP Wealstun should review the release arrangements for dual diagnosis prisoners to ensure that appropriate release arrangements and referrals are in place before a prisoner is released.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Wealstun informing them of the investigation and asking anyone with relevant information to contact him/her. No one responded.

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

17. The investigator interviewed five members of staff at Wealstun on 16 April 2019.

18. NHS England commissioned a clinical reviewer to review Mr Mulvey's clinical care at the prison. He joined the investigator for interviews with staff.

19. We informed HM Coroner for West Yorkshire (Western District) of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.

20. The Ombudsman's family liaison officer contacted Mr Mulvey's father to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Mulvey's father said that the prison did not tell him that they considered Mr Mulvey was at risk of suicide or that he had harmed himself in prison.

21. Mr Mulvey's father received a copy of the initial report. He did not make any comments.

22. We also shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

Background Information

HMP Wealstun

23. HMP Wealstun is a Category C prison near Wetherby, West Yorkshire, which holds up to 833 men. Care UK provides health services.

24. In August 2018, Wealstun was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Wealstun was in August 2015. Inspectors reported that prisoners harmed themselves less than at similar prisons. They found that suicide and self-harm preventions plans (ACCT) were of good quality, with consistent case management and a high level of continuing care. Prisoners being managed under ACCT procedures said that they felt well supported.

26. Inspectors also reported that an appropriate range of mental health services was provided, and information about risk was shared appropriately with relevant stakeholders.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2018, the IMB reported that prisoners at Wealstun harmed themselves less than at other prisons in the region. They also reported that they were concerned about the quality of the records staff made in ACCT documents and the monitoring of prisoners being managed under ACCT procedures. However, they also identified new initiatives that they thought might address this.

Previous deaths at HMP Wealstun

28. We have investigated the death of one other prisoner at Wealstun since February 2016. Our investigation into this death is currently suspended, as we are awaiting action from third parties, and the report has not yet been issued.

Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be

irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

30. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

31. Mr Robert Mulvey was convicted of several offences from 2002 onwards, usually receiving community sentences or fines. In 2005, he was diagnosed with schizophrenia (a long-term mental health condition, symptoms of which include hallucinations and delusions which prevent the patient from always being able to distinguish their thoughts and ideas from reality). Mr Mulvey was prescribed antipsychotic medication for several years but was not always compliant with this. In 2013, he was admitted to a psychiatric unit for several weeks for treatment under the Mental Health Act.

32. By 2018, Mr Mulvey was prescribed a fortnightly depot injection of the antipsychotic drug zuclopenthixol. (A depot injection slowly releases antipsychotic medication into the body over a number of days or weeks.) Mr Mulvey last received the depot injection in May 2018, after which he did not attend his appointments. In October, he attended a review with a psychiatrist and agreed to start taking oral zuclopenthixol in tablet form every day.

33. Mr Mulvey also used heroin in the community and had been prescribed methadone (an opiate substitute medication) for several years. He was prescribed long-term antibiotics because of infected skin at needle sites.

34. On 15 October, Mr Mulvey was remanded in custody to HMP Leeds on charges of theft and harassment. He was released after ten days, having received a suspended sentence of eight weeks in prison. Mr Mulvey was also given orders not to contact the victims of his offence. It is unclear whether Mr Mulvey took his prescribed medication in the community after he was released from prison.

35. On 5 December, Mr Mulvey was convicted of breaching the terms of his restraining order and committing another theft. He was sentenced to seven months and twelve days in prison. This meant that he could be released on home detention curfew, if he was assessed as eligible, at any date from 19 January 2019. Otherwise, Mr Mulvey would be released on 15 March 2019.

36. Court staff recorded in the person escort record (a form that accompanies prisoners on all journeys to communicate information, including about risk factors) that Mr Mulvey had cut his wrists in 2007 but said that he would not harm himself while in prison. They also recorded that he had previously had a drug-induced psychosis but that he was not currently prescribed any medication. He said that his mental health had been “okay for years”.

HMP Leeds

37. A nurse assessed Mr Mulvey when he arrived at HMP Leeds on 5 December. He recorded that Mr Mulvey said that he had been diagnosed with bipolar disorder and was prescribed a depot injection. Mr Mulvey said that he had previously received treatment from a psychiatrist and stayed in a psychiatric hospital. He said that he had drunk bleach a week previously but had no current thoughts of suicide or self-harm. Mr Mulvey also said that he used heroin and illicit benzodiazepines (tranquilisers) in the community. The nurse referred Mr Mulvey to the reception GP, but not to the mental health team.

38. Later that evening, the reception GP prescribed methadone and a three-week course of diazepam (to treat benzodiazepine withdrawal). He did not prescribe antipsychotic medication.

39. An officer also interviewed Mr Mulvey on his first night in prison. She recorded that he had previously had drug-induced psychosis but had no current issues.

40. On 8 December, Mr Mulvey told an officer that he could hear voices. A nurse reviewed him, and recorded that Mr Mulvey said he was experiencing hallucinations and could hear voices, which he said was because of sleep deprivation. The nurse completed a referral to the mental health team.

41. On 12 December, a nurse assessed Mr Mulvey's mental health. Mr Mulvey told her that he had initially been diagnosed with bipolar disorder but he was later treated for schizophrenia. The nurse recorded that Mr Mulvey had delusional thoughts and ideas about demonic spirits. She recorded that she discussed the prescription of long-term antipsychotic medication but Mr Mulvey said that he was "not interested" in this. There is no record of any further input from the mental health team at Leeds.

42. On 17 December, Mr Mulvey told an officer, who was his keyworker, that he was homeless and his main concern was finding somewhere to live when he was released. Mr Mulvey said that he was waiting to hear about possible release accommodation.

HMP Wealstun

43. On 27 December, Mr Mulvey was transferred to HMP Wealstun. An officer interviewed him shortly after he arrived. She recorded that Mr Mulvey said that he had no safer custody issues and was happy to be at Wealstun.

44. On 28 December, a nurse conducted an initial substance misuse assessment. Mr Mulvey said that he wanted to maintain his current dose of methadone. He declined any psychosocial intervention from the substance misuse team and said that he had no current issues with his mental health.

45. Later that day, a nurse completed an initial health assessment. She identified that Mr Mulvey had previously received inpatient and outpatient treatment and medication for mental ill health. Mr Mulvey said that he had no current thoughts of suicide and self-harm. The nurse did not make a referral to the mental health team.

46. On 18 January 2019, Mr Mulvey asked an officer if he could remain in his cell "due to mental health reasons". The officer telephoned the mental health team, who booked an appointment to assess Mr Mulvey.

47. On 24 January, a mental health nurse assessed Mr Mulvey. She recorded that Mr Mulvey said that he had heard voices telling him to self-harm. Mr Mulvey also said that he had harmed himself in the previous 24 hours by pouring boiling water on his hand and banging his head on a wall. Mr Mulvey said that he had tried to take his life eight months earlier by drinking bleach, and he was happy to die as he would then "be with God". At 11.50am, she started ACCT procedures. A Custodial Manager (CM) set ACCT observations at a minimum of two per hour.

48. In the afternoon, a nurse assessed Mr Mulvey. She recorded that there was clear evidence of psychosis because Mr Mulvey presented as having hallucinations, thought disorder and delusions. She recorded that Mr Mulvey was distressed by his symptoms. She contacted the prison psychiatrist who prescribed oral zuclopenthixol.

49. An officer then interviewed Mr Mulvey as part of the ACCT procedures. He recorded that Mr Mulvey said that he had heard voices telling him to "damage himself". Mr Mulvey repeated what he had told a mental health nurse about his recent and previous self-harm, and said that he had no current suicidal thoughts or intentions. Mr Mulvey said that he was waiting to receive some anti-psychotic medication. He said that he was due for release in March and did not know what he was going to do then. Mr Mulvey said that he had good support from his parents, with whom he was in regular contact. An officer recorded that Mr Mulvey's key issues were that he was hearing voices, awaiting medication, and working with the mental health team.

50. At around 1.20pm on 25 January, Mr Mulvey made a deep cut up his left arm from his wrist. He said that he did not want to go to hospital, so a prison nurse treated the wound.

51. At around 1.40pm, a CM led Mr Mulvey's first ACCT case review, with a nurse. The CM told us that he started work at 12.45pm and on arrival, found that he had been sent an email appointing him as Mr Mulvey's ACCT case manager. He recorded that Mr Mulvey was not willing to engage with him or the nurse. The CM told us that Mr Mulvey said that he was not "in the right place" at that moment. The CM recorded that Mr Mulvey was at raised risk of suicide and self-harm (on a scale of low, raised or high) and increased his observations to a minimum of four per hour. He did not complete a caremap, a mandatory requirement of the first case review. The CM told us that he set a case review for the following day, when he hoped Mr Mulvey would be more willing to engage with them.

52. The CM led the case review on 26 January, with a nurse from the mental health team. He recorded that Mr Mulvey said that he had tried to take his life the previous day because he had seen demons. Mr Mulvey said that it had taken him time to settle down afterwards, which is why he had not engaged during the previous case review. He said that he was pleased that he had not taken his life and was happy to take his medication as prescribed. Mr Mulvey also spoke about his release and said that he had no plans in place yet and would like to speak to someone about housing. The nurse recorded that Mr Mulvey was evidently more stable than the previous day.

53. The CM concluded that Mr Mulvey was now at low risk of suicide and self-harm. He did not change the minimum level of observations. He entered one action on the ACCT caremap: for Mr Mulvey to keep taking his medication.

54. At lunchtime, an officer became concerned about Mr Mulvey and asked a nurse to review him. The nurse recorded that Mr Mulvey said that he was "seeing demons" and pointed to where they were in his cell. Mr Mulvey asked about his medication, and the nurse noted that his concerns eased when he told him that his next dose was due later that afternoon. Mr Mulvey said that his experiences were not as strong as the previous day and said that he had no thoughts of harming himself.

55. On 28 January, the Head of the Offender Management Unit, approved Mr Mulvey's release on home detention curfew, subject to suitable release accommodation being identified.

56. On 29 January, a Supervising Officer (SO), who was an offender supervisor, spoke to Mr Mulvey about where he might live when he was released. He noted that Mr Mulvey had completed an application for Nacro BASS (Bail Accommodation and Support Service) which provides hostel accommodation for people eligible for release from prison who do not have anywhere to live, and advised him that there could be a long waiting list.

57. On the same day, a prison GP reviewed Mr Mulvey. He recorded that Mr Mulvey spoke of "demons and angels" and of "praying in tongues", and concluded that he was acutely psychotic. Mr Mulvey said that he did not like taking zuclopenthixol and that it made him feel weak. The prison GP prescribed quetiapine as an alternative antipsychotic.

58. On 31 January, a CM led an ACCT case review, with a nurse. He recorded that Mr Mulvey was very open about why he harmed himself and said his thoughts of harming himself had reduced considerably. Mr Mulvey told the CM that he had agreed with his father that he could live with him on release, and asked the CM to tell a SO. (The CM emailed the information to the SO after the case review.) The CM reduced the frequency of ACCT observations to a minimum of two per hour.

59. On the same day, a prison GP reviewed Mr Mulvey as he had not taken his antipsychotic medication that morning. He recorded that Mr Mulvey said that he would only take the zuclopenthixol depot injection he had previously been prescribed in the community. The prison GP noted that Mr Mulvey's self-harming behaviour had settled, but he remained "acutely psychotic". He prescribed a weekly depot injection of 100mg of zuclopenthixol, and noted that this could be increased if Mr Mulvey tolerated it. A nurse administered the depot injection that afternoon.

60. On 4 February, a nurse reviewed Mr Mulvey. She recorded that he had experienced no side effects from the depot injection and said he felt "okay" with it. A nurse also recorded that Mr Mulvey said that he had no thoughts of suicide or self-harm.

61. On 5 February, Mr Mulvey's father telephoned the prison to tell them that Mr Mulvey's mother had died suddenly. A prison chaplain visited Mr Mulvey and told him.

62. Shortly afterwards, a CM led an ACCT case review, with a nurse and an officer. The CM recorded that Mr Mulvey engaged well and said his mother's death was hard to take in but he believed that she was in a better place. Mr Mulvey said that he hoped to be released on home detention curfew to attend his mother's funeral. The CM contacted the prison's Offender Management Unit and learned that they were waiting for Mr Mulvey's offender manager to approve his father's home as a release address. She asked Mr Mulvey if he would like to use an office telephone to speak to his father but Mr Mulvey declined and said that he would contact him later using a wing telephone. Mr Mulvey said that he did not have any thoughts of suicide or self-harm. The CM made no change to the level of risk or observations.

63. On 6 February, a prison chaplain visited Mr Mulvey. He recorded that Mr Mulvey was calm and reiterated that he hoped to be released on home detention curfew in order to attend his mother's funeral.

64. Later that morning, a CM led an ACCT case review, with a nurse and a SO. He recorded that Mr Mulvey engaged well and said that he felt okay. Mr Mulvey said that he did not wish to speak to a chaplain about his mother's death and wanted to deal with it himself. He again said that he thought his mother was in a better place. The CM also recorded that Mr Mulvey was open and honest about his drug use and mental ill health, and that he had a positive outlook about his release and future. The CM made no change to the level of risk or observations.

65. That afternoon, Mr Mulvey's offender manager approved his father's address for release on home detention curfew. Mr Mulvey's release was subsequently arranged for 8 February. His mother's funeral was due to take place on 14 February.

66. On 7 February, a drug and alcohol recovery worker visited Mr Mulvey. The substance misuse team had arranged a post-release appointment with a substance misuse support service in Bradford, for the morning of 12 February. She gave Mr Mulvey information about the appointment, ensured he knew where to go, and spoke about the support available to him in the community. The recovery worker also gave him harm minimisation advice ahead of his release. She told us that Mr Mulvey appeared to understand the information she had given him.

67. A prison GP then reviewed Mr Mulvey. He prescribed an increased dose of 200mg of zuclopenthixol and noted that the community mental health team would review this. A nurse administered the depot injection that afternoon, and spoke to Mr Mulvey about his post-release appointments with the substance misuse support service and his local job centre. (An appointment had been made for the day of Mr Mulvey's release for him to complete the relevant applications to receive unemployment benefit.) The nurse recorded that Mr Mulvey was pleased that he would be released the next day and that she had confirmed that he was aware when his next depot injection was due.

68. On the same day, the team administrator with the mental health team, faxed information about Mr Mulvey's release address, medication and GP details to his mental health keyworker at Bradford District Care Trust. The team administrator also sent a follow-up email.

69. At 8.45am on 8 February, a different CM led an ACCT case review, with a nurse. The CM held the case review in Reception ahead of Mr Mulvey's release. He told us that this role fell to him because he was assigned as assistant orderly officer, and one of the responsibilities of this role was to ensure the correct discharge of any prisoners due for release and to hold case reviews for any prisoners who were subject to ACCT procedures. The CM told us that he did not know Mr Mulvey before 8 February.

70. The CM recorded that Mr Mulvey was excited to be released and to be able to spend time with his family. He noted that Mr Mulvey did not raise any issues and said that he had no thoughts of suicide or self-harm. The nurse reminded Mr Mulvey of his post-release appointments. She recorded that Mr Mulvey said that he

felt better and there was no evidence of acute illness. Mr Mulvey left the prison after the case review.

Post-release

71. After his release, Mr Mulvey attended an appointment with his offender manager. She told us that they discussed Mr Mulvey's substance misuse, mental ill-health and his self-harm in prison. She said that she confirmed that Mr Mulvey had appointments and support from community services arranged. She said that Mr Mulvey told her that he had no current suicidal thoughts, was happy to be out of prison, and did not need any further support. She told us that Mr Mulvey did not present to her as having any current issues that required her to make an urgent referral to community health services. It is not clear if she was aware that Mr Mulvey's mother had just died.

72. On 12 February, Mr Mulvey attended his appointment at the substance misuse support service. They told him that they could not offer any drug support services because he was under the care of Bradford District Care Trust.

73. Mr Mulvey returned to his father's address and, shortly afterwards, jumped from the balcony on the eighth floor at about 3.50pm. He was taken to hospital where he underwent surgery and had blood transfusions, until doctors concluded that further efforts to save his life would be futile because of the extent of his injuries. Hospital staff confirmed his death at 9.25pm that evening.

Contact with Mr Mulvey's family

74. On 15 February, a prison family liaison officer telephoned Mr Mulvey's father. She offered condolences on behalf of the prison and asked Mr Mulvey's father if he would like to visit Wealstun, which he declined.

Post-mortem report

75. A post-mortem examination recorded the cause of death as multiple injuries.

Findings

Managing the risk of suicide and self-harm

76. Prison staff appropriately began ACCT procedures on 24 January when Mr Mulvey told them that he had harmed himself. Some positive, supportive actions were taken and several aspects of the ACCT procedures were well managed. For instance, there was mostly consistent case management, mental health professionals attended every case review, and additional case reviews were held when Mr Mulvey learnt that his mother had died and immediately before his release. However, some of the ACCT procedures were not managed in line with Prison Service policy.

First case review

77. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It instructs that the first case review must be held within 24 hours of the ACCT being opened and ideally immediately after the assessment interview. This is so that the issues that have led to the opening of ACCT procedures can be identified and addressed at an early stage.

78. A CM held Mr Mulvey's first case review on the afternoon of 25 January, over 24 hours after ACCT monitoring started. We note that the CM was notified by email that he would be the case manager on the morning of 25 January. He started work at lunchtime and held the case review shortly afterwards. It would not therefore have been possibly for him to hold the first case review within the first 24 hours. We are not satisfied that it was appropriate to allocate the CM as case manager in these circumstances, as it meant that one of the key mandatory requirements of the ACCT procedures could not be met.

79. PSI 64/2011 also instructs that the first case review must identify the prisoner's most pressing needs and identify appropriate actions to address those needs. It instructs that a caremap must be completed at the first case review, which should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview. Mr Mulvey chose not to engage in the first case review. In light of this and his recent self-harm, the CM appropriately increased the frequency of observations. However, he did not complete a caremap or take any other steps to identify and address Mr Mulvey's needs.

80. The CM told us that this was because Mr Mulvey's lack of engagement meant that they could not identify his issues. However, the assessment interview had identified Mr Mulvey's medication and work with the mental health team as issues which should have been addressed at his first case review and through the caremap.

81. We also note that Mr Mulvey's release on home detention curfew and resulting issues, including identifying and approving release accommodation, which became key aspects of later ACCT case reviews, were not included on the caremap at any time.

Assessing risk

82. The ACCT document provides staff with guidance on how to assess the level of risk of suicide and self-harm. It says that risk is high, for example, when the prisoner has frequent suicidal ideas not easily dismissed, there is evidence of acute or ongoing mental illness, or there are escalating patterns of self-harm. Risk is raised when suicidal ideas are frequent but generally fleeting, there is evidence of acute or ongoing mental disorder, or there is current self-harming behaviour. Risk is low when suicidal thoughts are fleeting and soon dismissed and there is no self-harming behaviour.

83. At the case review on 26 January, Mr Mulvey said that he had tried to take his life the previous day. We appreciate that he said that he was glad that he had not succeeded but we are concerned that the CM assessed his risk as low at this time. Our view is that Mr Mulvey's risk should have been considered as raised (as a minimum) so soon after he apparently tried to take his life and given his ongoing mental disorder.

84. We are also concerned that insufficient weight was given to the death of Mr Mulvey's mother on 5 February. Mr Mulvey had identified the support of his parents as a proactive factor and we consider that his mother's death should have been identified as a risk factor that might increase his risk of suicide or self-harm, regardless of how calm Mr Mulvey appeared to be about it in the immediate aftermath.

Final case review

85. Prison staff appropriately held a case review immediately before Mr Mulvey's release. However, a CM who had no prior knowledge of Mr Mulvey led the case review. His assigned case manager, told us that he was working on 8 February but was not notified that this was the day on which Mr Mulvey would be released. PSI 64/2011 instructs that the ACCT process will operate more effectively if there is continuity of attendance at case reviews. Our view is that it would have been appropriate for the CM to lead Mr Mulvey's final case review to ensure a consistent approach.

Informing and involving Mr Mulvey's family

86. PSI 64/2011 states that consideration must be given to involving the prisoners' family in ACCT case reviews, where this is thought to be beneficial. Mr Mulvey's father told us that prison staff did not tell him that Mr Mulvey had harmed himself in prison or was considered at risk of suicide. Given that ACCT procedures were open in Mr Mulvey's last days in prison and that he had applied to live with his father on release, we consider that it would have been beneficial to inform and involve Mr Mulvey's father in the ACCT procedures (subject to Mr Mulvey's consent), in order to give Mr Mulvey's family the best chance of supporting him after his release. We make the following recommendation:

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

- **Case managers are appointed promptly after ACCT procedures are initiated, and first case reviews are held within 24 hours of the start of ACCT monitoring.**
- **ACCT caremap actions are initiated at the first case review, are specific and meaningful, and identify all the issues identified at assessment interviews and case reviews.**
- **Case reviews consider all relevant information that affects risk, and only reduce the level of risk when indicated.**
- **Case managers lead the final case review before release from prison, whenever possible.**
- **Consideration is given to informing and involving the family of the prisoner in the ACCT process, particularly when release from prison is upcoming.**

Health provision

Mental health referrals

87. On arrival at Leeds, Mr Mulvey told a nurse that he had a mental health diagnosis and was prescribed a depot injection in the community. He said that he had previously received treatment from a community psychiatrist and in a psychiatric hospital. When he arrived at Wealstun, a nurse also identified that Mr Mulvey had received treatment in the community for mental health conditions. In light of this evidence of potentially significant mental ill health, we are concerned that Reception staff at both Leeds and Wealstun did not refer Mr Mulvey to their prison's mental health team.

88. The clinical reviewer, highlights National Institute for Health and Care Excellence (NICE) guidelines about the health of prisoners. They state that if a prisoner has ever seen a healthcare professional about a mental health problem or ever been prescribed medication for a mental health problem, they should be referred to the prison's mental health team.

89. An appropriate referral was made to the mental health team at Leeds when Mr Mulvey said that he was hallucinating and could hear voices. When he was assessed, Mr Mulvey said that he had delusional thoughts about demons but was not interested in medication. We share the clinical reviewer's concern that no further action was taken after this assessment.

90. The clinical reviewer is satisfied that the interventions Mr Mulvey received after his referral to the mental health team at Wealstun on 18 January, were timely and appropriate. Nevertheless, the clinical reviewer concluded that the earlier missed opportunities meant that the care that Mr Mulvey received in prison was not equivalent to that which he could have expected to receive in the community.

Release arrangements

91. Before Mr Mulvey's release from prison, healthcare staff ensured that he had a prescription written for methadone provision in the community and that he knew

when and where to go for his next depot injection. They contacted and updated his community mental health keyworker about his release arrangements. The clinical reviewer concluded that this was appropriate.

92. Prison healthcare staff arranged a post-release appointment for Mr Mulvey with a community substance misuse service. However, when Mr Mulvey attended the appointment on the day of his death, they said they could not provide any support for Mr Mulvey as he was already under the care of Bradford District Care Trust. The clinical reviewer concluded that the release pathway for dual diagnosis prisoners should be reviewed to ensure that they are directed to the correct service on release.

93. We make the following recommendations:

The Heads of Healthcare at HMP Leeds and HMP Wealstun should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate, and make a referral when indicated.

The Head of Healthcare at HMP Wealstun should review the release arrangements for dual diagnosis prisoners, to ensure that appropriate release arrangements and referrals are in place before a prisoner is released.

Inquest

94. The inquest into Mr Mulvey's death was heard on 10 May 2023. The Coroner concluded that Mr Mulvey's death was due to suicide.

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