Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr John Singleton, a prisoner at HMP Risley, on 10 September 2019

## A report by the Prisons and Probation Ombudsman

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## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE

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 John Singleton died in hospital on 10 September 2019, after being found hanging in his cell at HMP Risley on 1 September. He was 42 years old. I offer my condolences to Mr Singleton's family and friends.

On 31 August, staff started suicide and self-harm prevention procedures (known as ACCT) because they were concerned about Mr Singleton's increasingly paranoid behaviour. When an officer went to check on Mr Singleton on the morning of 1 September, he found that Mr Singleton had covered his observation panel and he could not get a response from him. I am concerned that rather than calling for urgent help on his radio, the officer went to the wing office to telephone the orderly officer. The orderly officer was dealing with another incident and staff did not enter Mr Singleton's cell until more than 14 minutes later.

While I cannot say for certain that a quicker response would have changed the outcome for Mr Singleton, we know that in a medical emergency, a delay of a few minutes may be critical.

The investigation found failings in the management of ACCT procedures and in applying the prison's policy on self-isolating prisoners. Also, Mr Singleton's compliance with his medication was not monitored as it should have been.

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 2020**

# Contents

# Summary

## Events

1. Mr John Singleton arrived at HMP Risley on 25 May 2019, after being sentenced to ten months in prison for attempted burglary.

2. Mr Singleton was prescribed antidepressants and epilepsy medication. He frequently did not collect his medication because he said that queuing up at the medication hatch made him anxious.

3. On 17 August, Mr Singleton began to isolate himself because he thought he was under threat from other prisoners. On 28 August, an officer completed a mental health referral form for Mr Singleton because he was concerned about his increasingly paranoid behaviour.

4. Staff started suicide and self-harm prevention procedures (known as ACCT) for Mr Singleton on the morning of 31 August, because he had displayed bizarre behaviour during the night. He was checked twice an hour.

5. At 7.39am on 1 September, an officer went to check on Mr Singleton and found that he had covered his observation panel. The officer called to Mr Singleton but could not get a response, although he thought he heard Mr Singleton making a shuffling noise. The officer saw through a crack at the side of the cell door that Mr Singleton had used his bed to barricade the door.

6. The officer went to the wing office to call the orderly officer and explained the situation. The orderly officer said he would come to see Mr Singleton as soon as he had finished dealing with an incident in the Care and Separation Unit (CSU).

7. The officer returned to Mr Singleton's cell and could no longer hear anything. He went to the CSU to get help and returned with the orderly officer and two other officers. They arrived at Mr Singleton's cell at 7.53am. They opened the cell door outwards, because of the barricade, went in and called a medical emergency code when they saw Mr Singleton hanging from his bed. Staff cut Mr Singleton down and started cardiopulmonary resuscitation (CPR), which ambulance paramedics continued when they arrived at 8.09am.

8. Paramedics managed to resuscitate Mr Singleton and took him to hospital. However, he never regained consciousness and died in hospital on 10 September.

## Findings

9. Staff did not create a caremap at Mr Singleton's first ACCT case review. They did not address Mr Singleton's outstanding mental health referral or his unwillingness to collect his medication. We also found that ACCT observations were carried out at predictable times.

10. Staff opened a Challenge, Support and Intervention Plan (CSIP) after Mr Singleton starting self-isolating but they did not address his access to medication, given he was unwilling to leave his cell to collect it.

11. Although staff took action in response to the message Mr Singleton's next of kin left on the prison's Safer Custody hotline on 29 August, they did not ring her back to let her know that they had done so.

12. The officer who found that Mr Singleton's observation panel was covered, and the orderly officer he informed, did not respond with sufficient urgency. This led to a 14-minute delay in staff entering the cell and calling for urgent medical assistance. Although we cannot say for certain whether a quicker response would have changed the outcome for Mr Singleton, we know that in an emergency situation a delay of a few minutes can be critical.

13. The clinical reviewer found that healthcare staff failed to monitor Mr Singleton's compliance with his medication and this aspect of his care was not equivalent to that he could have expected to receive in the community.

## Recommendations

- The Governor should ensure staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that staff:
    - set meaningful caremap actions, aimed at reducing the prisoner's risk to themselves, at the first case review; and
    - carry out ACCT observations at unpredictable times.
- The Governor should ensure that staff follow the prison's policy on self-isolating prisoners, including that staff ensure prisoners have access to their prescribed medication.
- The Governor should ensure that staff respond promptly to callers who leave messages on the prison's Safer Custody hotline.
- The Governor should:
    - produce a local protocol to instruct staff on what to do if they find a cell observation panel obscured; and
    - ensure that all staff understand the need to enter a cell promptly, subject to a dynamic risk assessment, when there is a potential risk to life, in line with PSI 24/2011.
- The Governor should:
    - share this report with the CM and discuss the Ombudsman's findings with him; and
    - share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Head of Healthcare and Pharmacy Manager should ensure a system is in place to monitor prisoners' compliance with medication and to take action where necessary.

# The Investigation Process

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

15. The investigator visited Risley on 16 September 2019. She obtained copies of relevant extracts from Mr Singleton's prison and medical records.

16. NHS England commissioned an independent clinical reviewer to review Mr Singleton's clinical care at the prison. They jointly interviewed five members of staff on 20 October.

17. We informed HM Coroner for Greater Manchester West District of the investigation. We have sent the Coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Singleton's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised the following:

    - Should Mr Singleton have been watched when he took his medication?
    - Was the telephone call she made to the prison on 29 August, saying she was concerned about Mr Singleton, recorded?
    - Were healthcare staff consulted when Mr Singleton refused food?
    - How often was Mr Singleton checked?
    - How long did it take to get into Mr Singleton's cell?

    We have addressed these issues in our report.

19. Mr Singleton's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

# Background Information

## HMP Risley

20. HMP Risley is a medium security training prison which holds over 1000 convicted men. Bridgewater Community Healthcare NHS Trust provides healthcare services in the prison. Greater Manchester West Mental Health Foundation Trust provide mental health services. Substance misuse services are provided by Change, Grow, Live (CGL). There is 24-hour healthcare cover.

## HM Inspectorate of Prisons

21. The most recent inspection of HMP Risley was in June 2016. Inspectors reported that support for prisoners at risk of suicide and self-harm was adequate but the quality of ACCT documentation varied and some did not demonstrate sufficient interaction between staff and prisoners. However, most ACCTs were multidisciplinary and monthly compliance checks had been introduced to improve the quality of ACCTs.

22. Inspectors found the mental health team was enthusiastic and well led. A weekly first point of contact meeting identified men needing immediate attention and those needing routine assessment were usually seen within two weeks.

## Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 March 2018, the IMB reported that 53% of prisoners on A-E Wings did not feel safe. The number of prisoners on suicide monitoring procedures at Risley had decreased.

## Previous deaths at HMP Risley

24. Mr Singleton was the eighth prisoner to die at Risley since September 2017. Of the previous deaths, two were self-inflicted, one was drug-related, one was a homicide and three were from natural causes. We have previously made recommendations about the management of ACCT procedures at Risley.

## Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of an ACCT is to try to determine the level of risk, how to reduce 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

26. As part of the process a caremap (a 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, Management of prisoners at risk of harm to self, to others and from others.

# Key Events

27. On 22 May 2019, Mr John Singleton was sentenced to ten months imprisonment for attempted burglary. It was not his first time in prison.

28. Mr Singleton was moved to HMP Risley on 28 May. During his reception health screen, he told a nurse he was taking medication for depression and anxiety, but had no thoughts of suicide or self-harm. Mr Singleton said he had developed epilepsy after a head injury and was prescribed epilepsy medication. A prison GP prescribed him antidepressants and epilepsy medication. He was not allowed to keep these in his possession and had to collect them daily from nurses at the medication hatch.

29. Mr Singleton's offender supervisor met him on 30 May. Mr Singleton told her he had experienced some gang issues in the past (connected to his brother's death) but was not expecting any problems at Risley. They discussed his offence and plans for his release on 23 September.

30. On 9 June, a nurse noted that Mr Singleton had not collected his epilepsy medication. Mr Singleton said he did not want to collect his medication as it made him feel anxious. The nurse referred Mr Singleton to see a doctor for a medication review.

31. A prison GP saw Mr Singleton on 22 June. They discussed Mr Singleton's previous seizures and he said he had experienced a seizure the week before (though there is no record of this). Mr Singleton said he felt anxious when he queued for medication, which is why he had not collected it. He assessed Mr Singleton and agreed he could keep a weekly supply of medication in his possession, to reduce his trips to the healthcare department. Mr Singleton did not attend a follow up appointment with the prison GP on 20 August and no reason was recorded.

32. Mr Singleton started to isolate himself on 17 August because he thought he was under threat from other prisoners, though he said he had not received any direct threats. Staff started a Challenge, Support and Intervention Plan (CSIP) which they forwarded to the Safer Custody Department. However, later that day Mr Singleton joined in association with other prisoners on the wing and told staff that he had felt paranoid before but no longer felt he needed to isolate himself.

33. After this, there were occasions when Mr Singleton said that other prisoners were shouting at him, including calling him a paedophile. Wing staff did not hear any of these comments. (Mr Singleton was on the Sex Offenders Register for a sexual assault in 2005.)

34. Officer A told the investigator that on 28 August, Mr Singleton told him that other prisoners were shouting that he was a paedophile and that his next of kin had killed herself. He said he stood on the landing for 15-20 minutes out of Mr Singleton's sight to hear what was being shouted. He heard nothing but when he went back to Mr Singleton's cell, Mr Singleton said the shouting was continuing. Officer A therefore made a mental health referral for Mr Singleton as he was concerned about his behaviour. He completed a paper referral, and left it in an out-tray in the wing office (but it was not collected the next day as it should have been). He also

made an entry in Mr Singleton's prison record that he had referred him. The same day, Officer A offered Mr Singleton a move to another wing, but he declined.

35. On 29 August, Mr Singleton's next of kin left a message on the prison's 'Keep Safe' line, asking for him to be moved to another prison or to the prison's Care and Separation Unit (CSU). She said her ex-partner was serving a life sentence in a different prison and had "put a price on [Mr Singleton's] head". In response, staff checked on Mr Singleton and offered him a wing move, but he said he would rather stay on the wing he was on until he could transfer to another prison. A prison manager sent an email to other establishments to ask whether they would accept Mr Singleton on transfer (although he only had three weeks until his release). This request was still outstanding at the time of his death.

36. On 30 August, Mr Singleton appeared agitated and said he had heard prisoners saying his next of kin had been killed or had taken her own life, and calling him a paedophile.

## 31 August

37. On 31 August, at around 4.00am, a night operational support grade (OSG) asked a nurse to assess Mr Singleton. The OSG said Mr Singleton had been awake all night and was acting bizarrely. Mr Singleton said he believed his sister had killed herself that evening. Staff managed to contact another member of Mr Singleton's family who said that this was not the case. However, Mr Singleton did not believe this. She said she would arrange a member of the mental health team to review Mr Singleton later that morning. She also suggested it might be appropriate for staff to start suicide and self-harm procedures (known as ACCT) for him. They did not do so at that stage.

38. A nurse visited Mr Singleton later that morning for a mental health assessment. She noted that an officer (unnamed) had told her that Mr Singleton had recently started to act bizarrely, but there was no suspicion he was taking illicit drugs. The nurse advised the officer to open an ACCT.

39. At 10.00am, an officer started ACCT procedures for Mr Singleton. She noted that he had displayed paranoid and bizarre behaviour and seemed in a low mood. She also noted that Mr Singleton had left his cell for a shower and had asked to telephone his next of kin. He was advised against doing so at that time (because staff thought it would upset him if his sister told him she thought there was a price on his head).

40. During the ACCT assessment interview, Mr Singleton said he felt stressed about his medication and wanted to work with the mental health team. Mr Singleton said he had no thoughts of suicide or self-harm. Staff completed an immediate action plan which noted Mr Singleton was to remain in a single cell and continue self-isolating, and that he had been referred to the mental health team. Staff set observations at two an hour.

41. During an ACCT check at 10.30am, Mr Singleton said he was worried about his sister as prisoners had been shouting that she had taken her own life. An officer allowed him to telephone his relative at 10.44am, and then his next of kin at 10.48am. The officer remained close by so she could speak to him afterwards and ensure other prisoners did not harass him.

42. Mr Singleton told the officer he felt anxious and said he did not know what the matter with him was. He said he had not been taking his medications for depression or epilepsy and he felt he needed them. The officer asked Mr Singleton if he felt he would harm himself, and he said he could not guarantee he would not. Mr Singleton said he was not sure if he did want to transfer to another prison and agreed that the CSU was not an appropriate location for him. Later, although he was self-isolating, Mr Singleton asked if he could come out of his cell, but it was not possible as the prison was locked down. During an ACCT check at 12.45pm, Mr Singleton asked to use the telephone again, but it was not possible at that time as the wing was still locked down. He was offered his medication, but declined it.

43. A prison manager chaired the first ACCT review at 3.30pm. Two officers and a mental health nurse attended along with Mr Singleton. A nurse noted during the ACCT review that Mr Singleton was hypervigilant, restless and agitated and made only fleeting eye contact, though they did manage to establish and maintain a rapport with him. Mr Singleton said he thought other prisoners on the wing were out to get him and that an officer had told them he had committed a sexual offence 20 years ago. Mr Singleton said prisoners were calling him a paedophile and he was sure prisoners would come into his cell that night. When challenged about how this would happen, Mr Singleton said corrupt prison staff would give prisoners their cell keys.

44. Mr Singleton also said that he had not collected any medication for four weeks as he was scared to go to the healthcare department. (Records show he had not collected it for two weeks and sporadically before that.) Mr Singleton said he had not taken any illicit substances, but said he smoked cannabis in the community.

45. Staff asked what they could do to make Mr Singleton feel safe. He said he wanted a transfer to another prison. Mr Singleton's offender supervisor said he would make enquiries, but it was unlikely as Mr Singleton only had three weeks of his sentence to serve. Mr Singleton declined a wing move, saying that prisoners all around Risley were aware of his alleged sexual offences. Despite reassurances and a reminder that he should use his cell bell in an emergency, Mr Singleton appeared paranoid and staff wondered whether he might have taken illicit drugs. He said he had no thoughts of suicide or self-harm, but that he felt safer remaining on half hourly ACCT checks. Staff kept observations at two an hour both day and night. They scheduled his next ACCT review for 2 September.

46. Later that afternoon, at 4.40pm, Mr Singleton refused his dinner, telling staff twice that he did not want it. (There is no record that he refused food at other times.)

47. An officer was the only member of staff covering the wing between 5.30pm and 8.30pm, and was responsible for all ACCT checks including Mr Singleton's. In his statement, the officer said that Mr Singleton pressed his cell bell on more than one occasion and seemed to want to chat. The officer thought Mr Singleton seemed paranoid. Mr Singleton told the officer that other prisoners had put something on social media about his next of kin, and that he was worried they would go after her, and him when he was released. The officer tried to reassure Mr Singleton that he had spoken to other prisoners and this was not the case.

48. Mr Singleton pressed his cell bell at 8.25pm and 8.55pm, to ask for his medication. An OSG who had taken over from the officer, telephoned the healthcare department, who said Mr Singleton needed to see a doctor before he could start

taking his medication again after not taking it for a couple of weeks. The OSG told Mr Singleton who seemed to accept this. At 10.20pm, he pressed his cell bell again to request paracetamol. He requested this again at 11.25pm.

49. At 11.40pm, the OSG responded to Mr Singleton's cell bell again. He asked for paracetamol and said he felt he was having a breakdown. She asked what he meant and he replied that he could not stand the noise and that he felt his head was going. She asked whether Mr Singleton wanted to speak to a Listener (a prisoner trained by Samaritans to support other prisoners in crisis) but he declined. She said she would speak to somebody in the healthcare department about getting him some paracetamol, which seemed to calm him. A member of healthcare staff agreed Mr Singleton could have paracetamol but nobody from the healthcare department visited him.

## 1 September

50. On 1 September, the OSG carried out ACCT checks on Mr Singleton at 6.05am and 6.35am. On both occasions, she recorded that Mr Singleton was on his bed watching television. She responded to Mr Singleton's cell bell at 6.50am, when he asked for some medication.

51. Officer A carried out an ACCT check on Mr Singleton at 7.05am. CCTV shows that he returned to Mr Singleton's cell door at 7.39am, for his next ACCT check. He spent two minutes trying to look through the observation panel and through gaps around the cell door. He told the police that he could not see into the cell as the observation panel was covered. He said he looked through a gap in the side of the cell door and saw part of Mr Singleton's bed propped against the door as a barricade. He called Mr Singleton several times. He got no response, but thought he could hear Mr Singleton sniffing and shuffling about in the cell. Officer A remained at the cell door for a few minutes and, in the meantime, heard over his radio that a prisoner in the CSU was threatening to harm himself with a ligature.

52. Officer A told the police that he went to the wing office to update all the ACCT documents and to telephone the orderly officer, a Custodial Manager (CM), for assistance with Mr Singleton. However, the CM was already ringing the office to ask Officer A for assistance with a prisoner who had barricaded his cell door in the CSU. Officer A told the CM he could not help, as Mr Singleton was on an ACCT and had covered his observation panel and barricaded his cell door. The CM told him to stay on the wing and he would come over as soon as the incident in the CSU had been resolved.

53. At 7.45am, Officer A returned to Mr Singleton's cell to try to get a response from him, but he could not hear him at all this time. He returned to the wing office after a couple of minutes to make an entry in Mr Singleton's ACCT, and returned to the cell. Officer A decided it would be quicker to go to the CSU to ask for assistance, as it was close to where he was. A response team were still with a prisoner there but the situation had been controlled, so the CM, and two officers returned to E Wing with Officer A. They arrived at Mr Singleton's cell at 7.53am and saw the observation panel was obscured with toilet paper.

54. The CM called out to Mr Singleton and tried to open the cell door, but was unable to do so because of the barricade. The CM used another key that enabled the door to

be opened outwards. It took about five minutes to undo the door. As it opened, Officer A saw Mr Singleton's bed and mattress was upended and that he was hanging from the bed frame. The CM squeezed past the obstruction and saw Mr Singleton hanging and immediately radioed a code blue emergency call at 7.58am. Staff in the control room immediately telephoned for an ambulance.

55. The CM used his anti-ligature knife to cut the ligature and Mr Singleton fell forwards, hitting his head on the bed frame. The CM checked Mr Singleton for vital signs and found none, so started cardiopulmonary resuscitation (CPR). Officer A left the cell to collect the emergency bag and defibrillator.

56. Three nurses and a senior nurse arrived at Mr Singleton's cell at 8.00am. They saw Mr Singleton lying unresponsive on the floor and a member of staff administering CPR. They checked Mr Singleton who had no pulse, no output and his pupils were fixed and dilated. The defibrillator had been attached and was advising no shock. The nurses took over CPR.

57. At 8.09am, ambulance paramedics arrived at the cell and took over Mr Singleton's care. They administered adrenaline and intravenous fluids and managed to detect a cardiac output. Paramedics intubated Mr Singleton and at 8.36am, an ambulance took him to hospital. He was admitted to the Intensive Care Unit (ICU) where he remained ventilated and had scans which showed no signs of brain stem activity.

58. Prison healthcare staff spoke to ICU staff about Mr Singleton daily. On 8 September, hospital staff said that Mr Singleton's condition had deteriorated and they had spoken to his family. The next day an officer carrying out bedwatch duties informed the prison that the hospital intended to withdraw Mr Singleton's treatment over the next 48 hours. Mr Singleton died on 10 September, at 5.20pm.

## Contact with Mr Singleton's family

59. When Mr Singleton was taken to hospital on 1 September, the prison appointed an officer as the family liaison officer (FLO). While the FLO was gathering information to contact Mr Singleton's next of kin, and a next of kin telephoned the prison. The FLO explained what had happened and agreed to meet Mr Singleton's next of kin at the hospital.

60. The prison contributed to the costs of Mr Singleton's funeral, in line with national guidance.

## Support for prisoners and staff

61. After Mr Singleton's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

62. The prison posted notices informing other prisoners of Mr Singleton's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Singleton's death.

## Post-mortem report

63. Mr Singleton's post-mortem report was unavailable at the time of issuing this report. The toxicology report found no trace of any illicit drugs. However, the report noted that the blood sample had been taken five days after Mr Singleton was found hanging in his cell, and that it was therefore possible that Mr Singleton had taken illicit drugs which had passed through his system and been eliminated from the body by the time the blood sample was taken.

# Findings

## Identifying and managing Mr Singleton's risk of suicide and self-harm

64. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow if they consider that a prisoner is at risk of suicide and self-harm.

65. Staff started ACCT procedures for Mr Singleton on 30 August because of his paranoid and bizarre behaviour. PSI 64/2011 says that a case review should be held within 24 hours of starting ACCT procedures and that staff should complete a caremap at the first case review. Caremap actions should be tailored to meet the individual needs of the prisoner and be aimed at reducing the risk to themselves.

66. Staff held a first case review with Mr Singleton on 31 August. However, they did not create a caremap. We are concerned that despite Mr Singleton's presentation during the case review, staff did nothing to address his lack of medication and did not refer him to the mental health team. Neither did they complete caremap actions to try to keep Mr Singleton safe. We would have expected actions to include a mental health review and to arrange access to his medication.

67. Also, we found that many of Mr Singleton's ACCT checks were carried out at regular, and therefore predictable, intervals. Staff should avoid this by slightly staggering the times prisoners are checked. We make the following recommendation:

    **The Governor should ensure staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that staff:**

    - **set meaningful caremap actions, aimed at reducing the prisoner's risk to themselves, at the first case review; and**
    - **carry out ACCT observations at unpredictable times.**

## Mr Singleton's self-isolation

68. There is currently no national guidance on managing prisoners who isolate themselves, but Risley has its own policy, published in January 2019. It sets out local arrangements to identify and manage prisoners who isolate themselves. It defines self-isolation as a prisoner who either partially or completely withdraws from the prison regime and spends the majority of time in their cell.

69. The policy says that self-isolation can occur when a prisoner feels threatened, or has a mental illness or a disability that might prevent engagement. Self-isolation can cause a prisoner to feel lonely and rejected and may affect their mental health. Staff need to remain vigilant, begin the support process by opening a Challenge, Support and Intervention Plan (CSIP) and informing the Safer Custody Department. Staff should interview the prisoner, offer support and review regularly, or at least every fortnight. Staff should encourage a prisoner to collect their meals, medication and canteen purchases, but as a last resort, these should be collected for the

prisoner. If a prisoner chooses to stop self-isolating, the CSIP must be closed and Safer Custody informed.

70. Mr Singleton had periods of self-isolation and on 29 August, told an officer that he was self-isolating as he had a 'price on his head'. Mr Singleton's next of kin telephoned the prison the same day and left a message on the Safer Custody hotline asking for him to be transferred as he was under threat. In response, staff gave Mr Singleton the opportunity to move wings, but he declined. A manager began paperwork to ask whether another prison would be willing to accept Mr Singleton for the remainder of his sentence. This was outstanding at the time of Mr Singleton's death.

71. Although we are satisfied that staff took action in response to the phone call from Mr Singleton's next of kin, we consider that someone should have rung her back to let her know that they had received her call and acted on it.

72. In the meantime, staff raised a CSIP for Mr Singleton to ensure he was supported and received his daily entitlements. This should include access to medication. The local policy says that prisoners should be encouraged to collect their medication but, as a last resort, this could be collected for the prisoner. This did not happen and Mr Singleton remained without medication.

73. We make the following recommendations:

**The Governor should ensure that staff follow the prison's policy on self-isolating prisoners, including that staff ensure prisoners have access to their prescribed medication.**

**The Governor should ensure that staff respond promptly to callers who leave messages on the prison's Safer Custody hotline.**

## Emergency response

74. Risley does not have a local policy to tell staff what to do if they find a cell observation panel obscured. It is particularly worrying when a prisoner on an ACCT covers his observation panel. In such circumstances, we would expect staff to ask the prisoner to remove the obstruction and if the prisoner fails to do so, to radio for urgent help from other staff and remain at the cell door.

75. In this case, Officer A found at 7.39am that Mr Singleton had blocked his observation panel and propped his bed against the door as a barricade and was not responding when called, although he thought he could hear Mr Singleton making a noise. He left the cell to go to the wing office and telephone the orderly officer. We consider that Officer A should have radioed for assistance and should not have left the cell area.

76. When he could no longer hear Mr Singleton at 7.45am, Officer A left the wing and went to the CSU as he thought this would be the quickest way of seeking help from colleagues. Again, we consider that he should have stayed by the cell and radioed for assistance, although we appreciate that he was in a difficult position because he knew the orderly officer – who would normally have been his first point of contact - was busy. We are satisfied that the officer recognised the urgency of the situation and tried to do his best in the circumstances.

77. Although we recognise that the CM was already dealing with a serious incident in the CSU and had limited numbers of staff at his disposal at that time of the morning, we consider that he should have reacted with greater urgency when Officer A told him that a prisoner on an ACCT had blocked his observation panel, barricaded his door and was not responding. As it was, other officers did not arrive at Mr Singleton's cell until 7.53am, around 14 minutes after Officer A first failed to get a response from him and it was another five minutes before they were able to open the door and enter the cell. We cannot say if this delay affected the outcome for Mr Singleton, although we do know that any delay may be critical in a medical emergency.

78. We do not criticise Officer A for not entering Mr Singleton's cell on his own. He knew Mr Singleton had mental health problems and he could not see what Mr Singleton was doing in the cell, so it was reasonable for him to consider that it was not safe for him to enter by himself. However, we are concerned that he was under the impression that he could never enter a cell during the night state unless three officers are present.

79. Prison Service policy set out in PSI 24/2011 says that in normal circumstances, the night orderly officer must give authority to unlock a cell during night state and no cell should be opened unless at least two or three members of staff are present. However, the PSI also says that the preservation of life must take precedence over security, and that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on their own, following an on-the-spot risk assessment.

80. We make the following recommendations:

**The Governor should:**

- **produce a local protocol to instruct staff on what to do if they find a cell observation panel obscured; and**
- **ensure that all staff understand the need to enter a cell promptly, subject to a dynamic risk assessment, when there is a potential risk to life, in line with PSI 24/2011.**

**The Governor should:**

- **share this report with the CM and discuss the Ombudsman's findings with him; and**
- **share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.**

## Clinical care

### Failure to collect medication

81. Mr Singleton had not collected his medication for epilepsy and depression regularly since June. He told a doctor he did not like to visit the healthcare department to

collect his medication every day, so he was prescribed weekly in-possession medication. He still did not collect it, and no action was taken.

82. The clinical reviewer found that the lack of monitoring of Mr Singleton's compliance with his medication was not equivalent to the standard of care he could have expected to receive in the community. We make the following recommendation:

**The Head of Healthcare and Pharmacy Manager should ensure a system is in place to monitor prisoners' compliance with medication and to take action where necessary.**

### Mental health care

83. We commend Officer A for making a mental health referral for Mr Singleton on 28 August.

84. The clinical reviewer was satisfied that the standard of Mr Singleton's mental health care was equivalent to that he could have expected to receive in the community.

## Inquest

85. At the inquest, held from 13 to 16 November 2023, the jury concluded that Mr Singleton died by suicide.

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