

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Degg, a prisoner at HMP Risley, on 29 September 2018

A report by the Prisons and Probation Ombudsman

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



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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 Paul Degg was found hanged in his cell at HMP Risley on 29 September 2018. He was 46 years old. I offer my condolences to Mr Degg's family and friends.

Mr Degg had significant mental health issues, including self-harming behaviour, and was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) on six occasions at Risley. He also had a history of substance misuse and was found under the influence of psychoactive substances (PS) on several occasions.

We found that, overall, Mr Degg was well-supported by ACCT procedures and the mental health team at Risley. However, we found that mental health staff did not always have input into Mr Degg's ACCT reviews as they should have done.

Mr Degg received appropriate support with his substance misuse, although he did not always want to engage with it. We found some instances where staff did not follow the prison's policy on PS by failing to submit intelligence reports when Mr Degg was suspected of being under the influence.

The officer who found Mr Degg did not call a medical emergency code as he should have done. Although this did not cause a delay in treating Mr Degg or affect the eventual outcome, I am concerned that staff at Risley are not following the correct medical emergency procedures, an issue we have raised before.

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

June 2019

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Summary

Events

1. Mr Paul Degg was sentenced to 32 months in prison for wounding with intent on 19 June 2017. He was moved from HMP Manchester to HMP Risley on 30 June 2017.
2. Mr Degg had schizophrenia and dissocial personality disorder, as well as a history of illicit substance misuse and self-harm. He was supported by the prison's mental health and substance misuse teams.
3. Staff monitored Mr Degg under suicide and self-harm prevention procedures (known as ACCT) on six occasions at Risley after he had self-harmed. He made serious attempts to take his life on 4 March, 5 August and 13 August 2018, requiring hospital treatment on each occasion. At times, due to his high level of risk, Mr Degg was placed under constant supervision.
4. Mr Degg was found under the influence of psychoactive substances (PS) on several occasions at Risley. Staff warned him of the dangers of using PS and the effects they could have on his mental health. His substance misuse worker attempted to engage him in psychosocial work to address his PS use, but he did not want to engage.
5. On 29 September at around 6.40pm, an officer carrying out an ACCT check found Mr Degg hanging from his cell window. The officer called for assistance, then entered the cell, cut down Mr Degg and started cardiopulmonary resuscitation (CPR). Other officers arrived and assisted with CPR until healthcare staff arrived shortly afterwards and took over.
6. Ambulance paramedics arrived at 6.58pm but were unable to resuscitate Mr Degg and he was declared dead at 7.15pm. Toxicology tests found that Mr Degg had PS in his system when he died.

Findings

7. Mr Degg had complex needs which resulted in him regularly self-harming, including three serious attempts to take his life. Overall, we found that he was well-supported by prison and healthcare staff and that his risk was appropriately managed.
8. However, we found that some of his ACCT reviews were not multidisciplinary as they should have been, in that some lacked input from the mental health team.
9. Given Mr Degg's complex needs, we are concerned that at the ACCT review four days before his death, his risk was reassessed as low and the frequency of his observations was reduced without input from the mental health team.
10. We found that Mr Degg received appropriate medication for his mental health conditions and had regular reviews with a psychiatrist.
11. We found some occasions where staff did not submit intelligence reports, in accordance with their own policy, when Mr Degg was suspected to be under the influence of PS.

12. Mr Degg told staff that he was under threat from other prisoners on 27 November 2017 and 19 September 2018. We found that staff acted in accordance with the prison's Violence Reduction Policy in submitting intelligence reports about Mr Degg's allegations and that he was appropriately moved to another wing on the second occasion.
13. The officer who found Mr Degg did not call a medical emergency code as he should have done. While this did not cause a delay in the emergency response or affect the eventual outcome for Mr Degg, it could be crucial in future incidents.
14. We found that some staff did not feel supported after Mr Degg's death and that a hot debrief was not held immediately after the incident.

Recommendations

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that there is a multi-disciplinary approach for all case reviews with relevant healthcare staff and other keyworkers providing detailed input if they are unable to attend.
- The Governor should ensure that staff adhere to the requirements of the prison's PS policy when prisoners are suspected of using PS.
- The Governor and Head of Healthcare should ensure that all staff are aware of the correct medical emergency codes and have appropriate training in the use of emergency call signs.
- The Governor should:
 - ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, that all those involved in the incident are invited to attend, and that an accurate written record of attendees is kept; and
 - undertake a review of post-incident processes to ensure that all staff involved in an individual's care are offered support following an unexpected death.

The Investigation Process

15. 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.
16. The investigator obtained copies of relevant extracts from Mr Degg's prison and medical records.
17. NHS England commissioned an independent clinical reviewer to review Mr Degg's clinical care at the prison.
18. The investigator and clinical reviewer jointly interviewed eight members of staff at Risley. The investigator also separately interviewed one member of staff and one prisoner. The interviews took place between October 2018 and February 2019.
19. We informed HM Coroner for Greater Manchester West District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. The investigator contacted Mr Degg's daughter to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. His daughter wanted to know if Mr Degg's mental health and medication were appropriately managed; whether prison was the right environment for him, given his mental health issues; whether he was observed appropriately under ACCT procedures; how his substance misuse issues were managed; and whether her previous complaints and concerns had been acknowledged by the prison.
21. We cannot comment on whether prison was the right place for Mr Degg as that is a matter for the courts and outside the Ombudsman's remit. We have addressed Mr Degg's daughter's other concerns in this report.
22. Mr Degg's family received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.

Background Information

HMP Risley

23. HMP Risley is a medium security training prison which holds over 1,000 convicted men. Bridgewater Community Healthcare NHS Trust provides healthcare services in the prison. Greater Manchester West Mental Health Foundation Trust provide mental health services and substance misuse services are provided by Change, Grow, Live (CGL). There is 24-hour healthcare cover.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Risley was conducted in June 2016. Inspectors found that the daily regime was not being delivered. Inspectors were told that difficulties in industrial relations had led to significant regime cuts in recent months. They found that about a third of prisoners remained in their cells during the working day. They noted that Risley did not provide enough full-time activity to meet the needs of the population, and attendance and punctuality in learning and skills activities were poor.
25. There was evidence to suggest that the availability and threat of psychoactive substances (PS) at Risley was undermining prisoner wellbeing and was a major challenge to the stability of the prison. Nearly two-thirds of prisoners said it was easy to obtain drugs, including PS, at Risley. Inspectors found that health services were reasonable but the requirement to respond to PS-related incidents placed significant additional demands on the services. They noted that substance misuse services were good, with a range of excellent recovery-focused interventions delivered by a well-integrated and skilled drugs team.
26. Inspectors noted that levels of violence and self-harm were comparable to other prisons and that useful and effective work was in place to support prisoners in crisis. However, around one fifth of prisoners said they felt unsafe at the time of the inspection.

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 31 March 2017, the IMB was greatly concerned with the use of illicit drugs in the prison and the additional problems caused by PS. The Board noted that the high levels of substance misuse were a challenge for staff and that there was a lack of drug dogs. The Board noted that there were problems running the prison due to the reduction in staffing levels. They said that this had an adverse effect on the welfare of prisoners who were locked in their cells for unacceptable periods.

Previous deaths at HMP Risley

28. Mr Degg was the eighth prisoner to die at Risley since August 2015. Of the previous deaths, two were self-inflicted, two were drugs related and three were from

natural causes. There have been four deaths since Mr Degg's, three from natural causes, one homicide and one awaiting classification. We have previously made recommendations about ensuring healthcare staff attend ACCT case reviews and staff using the correct medical emergency code.

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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.
30. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
31. 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.

Psychoactive substances (PS)

32. PS (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
33. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.
34. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

35. On 19 June 2017, Mr Paul Degg was sentenced to 32 months in prison for wounding and grievous bodily harm with intent. He had been in prison before. Mr Degg was sent to HMP Manchester where reception staff identified that he had a history of self-harm and substance misuse, as well as a diagnosis of dissocial personality disorder and schizophrenia. Mr Degg said that his mood was low as he had been unable to contact his daughter. Reception staff started suicide and self-harm prevention procedures (known as ACCT) and arranged for Mr Degg to be supported by the mental health in-reach team and the substance misuse team.
36. On 26 June, staff at Manchester stopped ACCT monitoring after Mr Degg said he had contacted his daughter and he was engaging with the substance misuse and mental health teams. Staff assessed his risk as low and arranged a post-closure review for 3 July. However, Mr Degg was transferred to HMP Risley before the ACCT post-closure review took place.
37. Mr Degg arrived at HMP Risley on 30 June. Reception staff identified that he was in the ACCT post-closure stage and an offender supervisor interviewed him about his risk of suicide and self-harm. The offender supervisor wrote in Mr Degg's prison record that he said he was happy to be at Risley as it was closer to home and his nephew was also there. Mr Degg said he had no thoughts of suicide or self-harm.
38. A nurse completed Mr Degg's reception healthcare screening. She noted he had no thoughts of suicide or self-harm but referred him to the mental health team due to his history and recent ACCT. A GP prescribed Mr Degg with the same medication he had received at Manchester. Staff placed Mr Degg on C Wing.
39. On 3 July, a GP saw Mr Degg and reviewed his substance misuse medication. Mr Degg told the GP that he was being victimised on the wing because he was using buprenorphine (used to treat opioid addiction). The GP noted that Mr Degg's mood was up and down, he was experiencing auditory hallucinations and he was feeling paranoid, but Mr Degg said that he currently felt stable. The GP changed Mr Degg's substance misuse medication from buprenorphine to methadone.
40. On 4 July, a psychiatric nurse from the mental health team at Manchester, contacted Risley's mental health team by phone to let them know that Mr Degg had an outstanding psychiatric appointment to review his medication. The psychiatric nurse noted in Mr Degg's medical record that he had handed over Mr Degg's care to Risley who agreed to follow up this action. Mr Degg was allocated a mental health keyworker on 11 July.
41. On 13 July, Mr Degg had a second healthcare screening with a nurse. He said he was feeling better on methadone.
42. On 17 July, Mr Degg was suspected of being under the influence of psychoactive substances (PS). He was assessed by healthcare staff but he denied using anything. He was not given his methadone that evening. Staff did not submit an intelligence report.
43. On 18 July, Mr Degg made superficial cuts to his arm and an officer started ACCT monitoring. The first ACCT review was chaired by a custodial manager (CM) and attended by a supervising officer (SO), an officer and a nurse from the mental

health team. Mr Degg said that he had self-harmed as a coping mechanism but he did not want to die. He said he was unhappy that his methadone was withheld the previous evening and denied that he had been under the influence, saying he was affected by his prescribed medication. Staff assessed his risk as raised and observed him twice an hour. Mr Degg had four further multidisciplinary ACCT reviews until staff stopped ACCT monitoring on 14 August.

44. On 17 August, healthcare staff withheld Mr Degg's medication after he was suspected of being under the influence of an illicit substance. A nurse noted that he was unsteady on his feet and slurring his words. We found no evidence that prison staff were made aware that Mr Degg was under the influence and no intelligence report was submitted.
45. On 18 August, Mr Degg had his anti-psychotic medication by depot (slow-release) injection, as prescribed. He told the nurse that he found the medication to be beneficial and he reported no side effects. Mr Degg was due to see a doctor for a mental health review on 24 August but he did not attend. His medication continued as prescribed.
46. On 25 September, Mr Degg was involved in a fight and placed on basic regime. Later that day he was found to be under the influence of PS. He was seen by healthcare staff who submitted an intelligence report. Mr Degg was moved to D Wing. By 3 October, Mr Degg was back on standard regime.
47. On 30 October, Mr Degg attended the healthcare unit for his depot injection. A nurse wrote in Mr Degg's medical record that he did not think his medication dose was correct and he wanted to see his mental health keyworker. The nurse also said that Mr Degg was concerned that he would need to go into a hostel on release from prison. His mental health keyworker subsequently arranged an appointment to see Mr Degg on 31 October but he did not attend.
48. Mr Degg was found to be under the influence of PS on 1 November. Healthcare staff saw him and submitted an intelligence report. The following day, he was found in possession of drug paraphernalia and hooch (illicitly brewed alcohol). Staff put him on basic regime and submitted an intelligence report. On 3 November, when a SO went to speak to Mr Degg to tell him that he would be on basic regime, she found him to be in a low mood and he expressed thoughts of self-harm. The SO started ACCT monitoring.
49. The first ACCT review on 4 November was chaired by a CM and attended by a nurse. Mr Degg said that he was frustrated that he had not received his medication after staff thought he was under the influence. He continued to deny that he had taken anything. Staff completed a caremap with actions for Mr Degg to engage with the substance misuse and mental health teams. Mr Degg had two further multidisciplinary reviews before staff stopped ACCT monitoring on 13 November. Staff recorded that he had made good progress, was abstaining from using PS and had acknowledged the impact his substance misuse was having on his mental health.
50. On 27 November, Mr Degg's daughter contacted the prison's safer custody team to say that her father wanted to move to another wing. She was worried that he would not tell staff but would end up harming himself instead. A SO spoke to Mr Degg about his daughter's concerns. Mr Degg said he was being intimidated by other

prisoners on D Wing but he did not give any further information. The SO submitted an intelligence report.

51. On 14 December, a consultant forensic psychiatrist assessed Mr Degg. She noted that Mr Degg was hearing voices and had thoughts of harming others. She noted his mood was irritable but difficult to assess. She recorded that Mr Degg should not share a cell with anyone. She increased his depot injection dose from 80mg to 100mg.
52. On 18 December, a SO started ACCT monitoring again after Mr Degg opened wounds on his wrists. A nurse and the SO were concerned as they had not seen Mr Degg in such an agitated state before and he made clear statements that he wanted to kill himself. As a result, he was placed on constant supervision on 20 December. Staff identified a trigger as the birthday of his daughter (25 December) who had died, so he remained on constant supervision until 28 December.
53. On 6 January 2018, Mr Degg was found to be under the influence. He was seen by healthcare staff and placed on basic regime. Staff submitted an intelligence report.
54. On 24 January, Mr Degg made cuts to his wrist so was again placed on constant supervision.
55. On 29 January, Mr Degg had a mental health review with the consultant forensic psychiatrist who noted that Mr Degg reported low mood, poor appetite, weight loss and poor sleep pattern. He admitted to using PS in prison but said he had not used any in the last three weeks. She noted that Mr Degg reported hearing voices telling him to hit people and he said he self-harmed when he felt stressed. She increased Mr Degg's fortnightly depot injection from 100mg to 140mg and also prescribed medication to help him sleep. Staff took Mr Degg off constant supervision on 30 January.
56. Mr Degg's methadone dose was reduced on 7 February and he told, a substance misuse worker that he was not happy about this. She saw him again on 13 February and he said he was not feeling well because of the methadone reduction. She gave him a relapse prevention booklet and harm reduction advice, but she noted in his record that he walked away while she was talking to him so he did not fully engage with her. Mr Degg completed his methadone detox programme on 15 February.
57. Staff stopped ACCT monitoring on 20 February, after a total of 23 ACCT case reviews between 18 December 2017 and 20 February 2018.
58. On 4 March, Mr Degg made severe cuts to his arm which resulted in him being admitted to hospital for surgery to repair an artery. Staff started ACCT monitoring and he was placed on constant supervision while at the hospital and this continued when he returned to the prison on 8 March.
59. On 12 March, Mr Degg met with a nurse and the consultant forensic psychiatrist. Mr Degg said that he cut himself to relieve tension but he had no thoughts of self-harm or harming others. The nurse noted that his mood was low and he appeared anxious. Mr Degg said he had issues from his past that he needed to address but he did not feel able to talk about them. The consultant forensic psychiatrist increased his amitriptyline (antidepressant) medication from 150mg to 200mg, and

his promethazine (sleeping pills) from 25mg to 50mg and agreed to review him in four to six weeks to consider increasing the dose of his depot injection.

60. Staff stopped constant supervision on 15 March and reduced Mr Degg's observations to five an hour.
61. On 19 March, Mr Degg was found to be under the influence and was seen by healthcare staff. A substance misuse worker spoke to him and he denied using any illicit substances. Staff submitted an intelligence report.
62. By 25 March, staff had reduced Mr Degg's ACCT observations to two an hour. At around 5.15pm, he cut his wrist and said he needed an ambulance. A nurse attended his cell and treated his wounds. She noted that Mr Degg was disappointed that he had not severed an artery again. Staff increased his observations to five an hour. Shortly afterwards, Mr Degg cut his wrist again, this time severing the artery, and he had to return to hospital for treatment. On return to the prison later that evening, staff placed him on constant supervision. He remained on constant supervision until 29 March when he was moved to B Wing.
63. On 4 April, while on hourly observations, Mr Degg cut his arm again so staff moved him to a constant supervision cell. Mr Degg said he harmed himself because there were cockroaches in his cell on B Wing and he did not want to stay there. Staff moved him to E Wing and maintained hourly observations. Mr Degg said he was happy to move to E Wing and said he no longer needed to be on an ACCT.
64. On 8 April, Mr Degg was found to be under the influence and healthcare staff attended. His medication was withheld that evening for clinical reasons. Staff submitted an intelligence report.
65. On 9 April, Mr Degg reopened the cut on his left wrist and refused to have his wrist sutured by healthcare. He said he had done this because he did not get his medication the previous evening. He said he would cut himself again so staff resumed constant supervision. Mr Degg was assessed by the consultant forensic psychiatrist and a nurse. He said he had thoughts of cutting himself but no thoughts of other self-harm or of harming others. The nurse noted that he had razors in his possession and she requested that staff remove these from him. Mr Degg said he was feeling paranoid that others wanted to harm him and he was worried that he was going to lose his flat in the community. The consultant forensic psychiatrist suggested an increase in Mr Degg's depot injection from 140mg to 160mg and to adjust his mood stabilising medication. However, a consultant psychiatrist subsequently disagreed with the consultant forensic psychiatrist suggested change in medication as he felt there were associated risks. As a result, Mr Degg's medication did not change. Staff stopped constant supervision on 11 April.
66. On 16 April, Mr Degg asked to move from E Wing so staff moved him back to B Wing. He said he was happy with this and his ACCT observations were reduced to three times an hour.
67. On 2 May, Mr Degg was moved to C Wing. Mr Degg agreed to this move as staff considered it would facilitate his engagement with substance misuse services and education. Staff continued ACCT monitoring until 18 May. Mr Degg had a total of 27 ACCT reviews between 4 March and 18 May.

68. Staff started ACCT monitoring again on 12 June after Mr Degg said he felt his medication was not working and he was having thoughts of taking his life. He said that he was feeling paranoid and felt this was due to using PS. He said he felt safer while being monitored on an ACCT.
69. On 18 June, Mr Degg had an assessment with the consultant forensic psychiatrist and a nurse. The consultant forensic psychiatrist noted that her previous suggestion to increase his depot injection and introduce an additional mood stabiliser had not been agreed. Mr Degg said that he was experiencing paranoia and that he tried to avoid other prisoners on the wing. Mr Degg appeared low in mood but was happy when talking about his daughter who he said was expecting a son in July. He was concerned that he might have to go into a hostel on release and the consultant forensic psychiatrist suggested a meeting with his offender supervisor and a further multidisciplinary meeting nearer to his release date.
70. On 30 June, staff found Mr Degg under the influence. He was seen by healthcare staff but they did not submit an intelligence report.
71. Staff continued ACCT monitoring until 3 July. Mr Degg had four multidisciplinary ACCT reviews between 12 June and 3 July.
72. On 5 August, Mr Degg attempted to hang himself and was taken to hospital. Staff started ACCT monitoring and he was placed on constant supervision on D Wing. Mr Degg said he had self-harmed because he was nervous about being released from prison and he heard voices telling him to do this. He asked to be placed on constant supervision. He remained on constant supervision until 8 August when staff moved him to a different cell on D Wing and observed him five times per hour. Staff recorded in his ACCT review paperwork that Mr Degg was happy to move to D Wing as he had supportive friends there.
73. On 13 August, while Mr Degg was on hourly observations, he was found with a ligature around his neck again and said he wanted to die. Staff moved him to A Wing and placed him on constant supervision. Mr Degg was assessed by the consultant forensic psychiatrist and a nurse. The consultant forensic psychiatrist assessed Mr Degg's risk as very high. She noted that he should continue with his current medication and suggested a multidisciplinary meeting in a month's time to discuss his release plans. Staff kept Mr Degg on constant supervision until 17 August.
74. On 4 September, Mr Degg refused to attend a mental health review meeting with a nurse but he did not give a reason. He did, however, attend an ACCT review later that day.
75. On 6 September, Mr Degg refused to attend an ACCT review, saying he was tired. A nurse and a CM went to his cell to speak to him. The nurse noted that he seemed to be tired but he was polite and appropriate.
76. On 18 September, Mr Degg was found to be under the influence again. He was seen by healthcare staff and placed on basic regime. Staff did not submit an intelligence report. He refused to attend an ACCT review that day.
77. On 19 September, Mr Degg told an officer that he was under threat on A Wing from the friends of his victim and wanted to move to B Wing. The officer submitted an intelligence report.

78. Mr Degg was moved to E Wing on 20 September. The following day, a CM chaired an ACCT review which was also attended by the prison chaplain and a nurse. Mr Degg said he was happy on E Wing. The CM moved Mr Degg back to standard regime and arranged for him to have a television. Staff agreed to reduce his observations to one observation an hour but continued to assess his risk as raised.
79. On 25 September, a CM chaired another ACCT review with Mr Degg which was also attended by a prison chaplain. A nurse was unable to attend the review and had tried to phone the wing to provide input but could not get through to anyone. The nurse made a note in Mr Degg's medical record to this effect. At the review, the CM assessed Mr Degg's risk as low and reduced his observations to one observation every two hours.
80. The CM told the investigator that he felt confident to do this without input from the mental health team. He said he had a good prior knowledge of Mr Degg, he had experience of undertaking ACCT reviews and he was supported by the chaplain in making the decision in the absence of the mental health team. The CM said that Mr Degg's mood had improved, he was no longer on basic regime, and appeared positive.
81. On 27 September, Mr Degg was moved to D Wing. No one recorded the reason for the move and it has not been possible to establish the reason during this investigation.
82. On 29 September at 5.15pm, an officer checked Mr Degg and saw him eating his dinner and watching television. When the officer returned to carry out the next ACCT check at around 6.45pm, he found Mr Degg had made a ligature from a sheet and was hanging from his window. The officer radioed for staff assistance and then immediately entered the cell. He cut down Mr Degg and started cardiopulmonary resuscitation (CPR). Another officer and a CM responded promptly and assisted the officer in trying to resuscitate Mr Degg. Two nurses arrived shortly afterwards and took over CPR.
83. The control room log shows that the officer called for assistance at 6.48pm and an ambulance was called at 6.49pm. Paramedics arrived at 6.58pm but were unable to resuscitate Mr Degg and he was declared dead at 7.15pm.

Contact with Mr Degg's family

84. Mr Degg's daughter was listed as his next of kin. The governor and a prison chaplain visited Mr Degg's daughter at her home address at approximately 9.50pm on 29 September to inform her of her father's death. The prison contributed to the cost of Mr Degg's funeral, in line with Prison Service instructions.

Support for prisoners and staff

85. Some members of staff who were directly involved in the emergency response said that they were offered support by the prison's care team and felt supported by managers and other colleagues. However, staff were not invited to a hot debrief immediately after the incident. Some staff who had worked closely with Mr Degg said they had been affected by his death and did not feel supported.

86. The governor posted a notice for prisoners informing them of Mr Degg's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Degg's death.

Post-mortem report

87. The post-mortem report concluded that Mr Degg's death was due to hanging. PS was found in his blood but it was not possible to establish what impact that may have had on his decision to take his life.

Findings

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

88. Prison Service Instruction 64/2011, *Management of prisoners at risk of harm from self, from others and to others (Safer Custody)*, sets out a list of risk factors and triggers that might increase the risk of suicide and self-harm. These include mental health and substance misuse issues, which applied to Mr Degg. Reception staff at Risley identified that Mr Degg was in the post-closure phase of an ACCT when he transferred from Manchester and they took appropriate action to identify any risk issues and offer him appropriate support.
89. Mr Degg had complex needs which resulted in regular self-harm, including three serious attempts to take his life. During his time at Risley, Mr Degg was monitored under ACCT procedures six times. We found that, up to 25 September 2018, he was supported well by prison and healthcare staff and that staff set observations at a level appropriate to his risk.
90. Mr Degg had a high number of case reviews and we found that the vast majority were multidisciplinary, involving healthcare professionals and other keyworkers who were involved in his care. However, some case reviews were carried out without input from healthcare staff, specifically the mental health team. This was the case for five of the 23 ACCT reviews held between 18 December 2017 and 20 February 2018, five of the 27 reviews held between 4 March and 18 May 2018, and six of the 20 reviews held between 5 August and 25 September 2018.
91. We found that healthcare staff did not attend Mr Degg's final ACCT review on 25 September and we are concerned that, given Mr Degg's complex needs, a CM reassessed his risk as low and reduced the frequency of observations without input from the mental health team. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that there is a multidisciplinary approach for all case reviews with relevant healthcare staff and other keyworkers providing detailed input if they are unable to attend.

Mental health

92. The clinical reviewer concluded that Mr Degg's mental health care was equivalent to that which he could have expected to receive in the community. She considered that Mr Degg received extensive mental health support, his medication was administered in a consistent and timely manner, and he had regular reviews with a psychiatrist where adjustments were made to his medication to improve his mental health symptoms and reduce his risk.
93. The clinical reviewer said that Mr Degg's use of PS had a detrimental effect on his mental health but it was not possible to conclude how this contributed to his decision to take his life, a fact also identified by the pathologist.

Substance misuse

94. We found that Mr Degg was offered appropriate support to help him address his substance misuse issues. The clinical reviewer noted that his opiate substitution medication was continued when he arrived at Manchester and on transfer to Risley. Mr Degg's request to change his medication from buprenorphine to methadone was actioned and he was correctly monitored.
95. However, Mr Degg's use of PS meant that, at times, his methadone was withheld for reasons of safety. The clinical reviewer concluded that this was the correct decision. Mr Degg had a named keyworker who tried to engage him in psychosocial work and she, along with other healthcare professionals, frequently reminded Mr Degg of the dangers of using PS and, in particular, the effect it was having on his mental health.
96. The prison's psychoactive substance strategy policy, *A Strategy to manage the threat and risk of New Psychoactive Substances (PS)*, states:

"It [the policy] sets out clear actions that must take place in the event of every incident of suspected use, possession or supply [with the aim to] ensure that we are all confident in how to deal with prisoners who are suspected of using PS or to be involved in the distribution or supply of PS and that we continue to tackle the problem with a holistic approach."

The policy goes on to list the required actions to be taken by staff when a prisoner is suspected of being under the influence of PS. These actions include alerting healthcare, making an entry in the prisoner's record and submitting an intelligence report.

97. We found six occasions where staff correctly submitted intelligence reports when Mr Degg was found to be under the influence of PS. However, there were three occasions when this did not happen, one of these being eleven days before Mr Degg's death. We therefore make the following recommendation:

The Governor should ensure that all staff adhere to the requirements of the prison's PS policy when prisoners are suspected of using PS.

Violence reduction

98. The prison's Violence Reduction Policy, dated December 2017, states "*Where staff are suspicious that violence is occurring i.e. bullying, threats, these should be reported to Security via Mercury Intelligence Reports.*" The policy requires staff to complete additional paperwork and provide additional support where they have witnessed or seen evidence of violence towards a prisoner. However, this was not relevant for Mr Degg as we found nothing to indicate that he had been subjected to physical violence at any time.
99. On 27 November 2017, after his daughter contacted the prison with concerns about her father's safety, Mr Degg told staff that he was being intimidated by other prisoners on D Wing although he did not give any further details. We found that staff acted in accordance with the prison's policy by submitting an intelligence report. Mr Degg remained on D Wing until 29 March 2018 and we found no evidence that he made any further allegations of intimidation, threats or bullying

during that time. The prison told us that they did not receive any further concerns from Mr Degg's daughter.

100. Similarly, on 19 September 2018, Mr Degg said that he was being threatened on A Wing but he did not give any further details. Again, we found that staff acted in accordance with the prison's policy by submitting an intelligence report. Furthermore, staff quickly met Mr Degg's request for a move from A Wing, moving him to E Wing the following day.
101. Staff did not record the reason why Mr Degg moved from E Wing to D Wing on 27 September 2018. The Head of Safer Custody told the investigator that wing staff thought Mr Degg may have requested the move because he was in debt but it has not been possible to establish whether this was the case.
102. Mr Degg admitted to using PS and we found evidence of this in intelligence reports, medical records, ACCT documents and prison records. It is possible that Mr Degg was being threatened because of drug debts, but he did not tell anyone that this was the case and he did not provide details of any threats towards him. We consider that staff appropriately responded to Mr Degg's requests to be moved to different parts of the prison and offered him appropriate support when he asked for it. We are satisfied that staff followed the correct procedure on the two occasions when Mr Degg said he was being threatened.

Emergency response

103. PSI 03/2013, 'Medical Emergency Response Codes', says that all staff must be made aware of and understand their responsibilities during medical emergencies. The PSI requires staff to radio a medical emergency code to communicate the nature of a medical emergency efficiently. The code triggers healthcare staff to take the relevant equipment to the scene, and control room staff to call an ambulance without delay.
104. When the officer found Mr Degg hanging in his cell, he should have used a medical emergency code blue, which indicates that a prisoner is unconscious or having breathing difficulties. He did not do so and instead called for urgent assistance. Although we found there was no delay in the emergency response and it did not affect the eventual outcome for Mr Degg, we are concerned that failure to use the correct emergency code could be significant in future incidents. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of the correct medical emergency codes and have appropriate training in the use of emergency call signs.

Staff support

105. PSI 64/2011 on Safer Custody says, "In line with PSI 08/2010 Post Incident Care, a 'Hot Debrief' must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. It may be useful to keep a record of those who attend." While staff said they felt supported by colleagues, managers and the prison's care team following

the death of Mr Degg, we found no evidence that a hot debrief was held immediately after the incident.

106. Due to Mr Degg's complex needs, many staff were directly involved in his care and had a close working relationship with him. We found that some members of staff had been significantly affected by Mr Degg's death, but they did not feel adequately supported. We therefore make the following recommendation:

The Governor should:

- **ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, that all those involved in the incident are invited to attend, and that an accurate written record of attendees is kept; and**
- **undertake a review of post-incident processes to ensure that all staff involved in an individual's care are offered support following an unexpected death.**

Inquest

107. The inquest, held from 2 to 9 April 2024, concluded that: "Mr Paul Degg died as a result of a self-applied ligature. His intention at the time of the act cannot be determined."

**Prisons &
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