Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man at HMP Hewell in January 2015

A report by the Prisons and Probation Ombudsman
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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*

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

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

The man was found hanged in his cell at HMP Hewell on 25 January 2015. I offer my condolences to his family and friends.

The man was on trial for two murders. Although healthcare staff had identified that he was likely to be at increased risk of suicide and self-harm if he was found guilty, they did not begin suicide and self-harm prevention procedures before the conclusion of the trial, even though a guilty verdict was the likely outcome. While not directly related to the circumstances of the man's death, the investigation found a need for improvements in segregation procedures and monitoring arrangements for prisoners assessed as at risk of suicide and self-harm. Staff also need to respond more effectively to medical emergencies, a matter I have raised with the prison a number of times before.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2015**

Contents

Summary

Events

1. The man was remanded to prison on 3 July 2014. He was held initially at HMP Birmingham, before moving to HMP Hewell in November 2014. At Birmingham, he was briefly monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT), twice, but was not considered at high risk of suicide or self-harm.

2. When the man arrived at Hewell, he was held in the segregation unit as there were no other single cells available and he was considered unsuitable for cell-sharing. He later refused to move to a standard wing, as he said he was at risk from other prisoners, or to Hewell's vulnerable prisoners' wing.

3. On 22 December, the man was still in the segregation unit and said he was thinking of hanging himself. Staff began ACCT procedures but assessed him as at low risk of suicide or self-harm. They closed the ACCT on 30 December. On 7 January 2015, he was moved to the healthcare inpatient unit to allow him a better living environment.

4. The man's trial started on 19 January. Healthcare staff agreed that this was a stressful time for him. On 20 January, a multidisciplinary team agreed that he would be at risk if he was found guilty and an ACCT should be opened at that point. They did not think that the man needed to be monitored by ACCT procedures in the meantime.

5. On Friday 23 January, the man came back from court early, as he had been ill. A doctor assessed him on Saturday 24 January and concluded that he would be fit for court the following Monday. No one who had any contact with him over the weekend had any concerns about him.

6. At 6.10am on Sunday 25 January, a healthcare assistant found the man hanged in his cell. A nurse examined him and decided he had died. Staff therefore did not attempt to resuscitate him.

Findings

7. Although staff anticipated that the man would be at risk if he was found guilty, we consider that there were sufficient concerns to have opened an ACCT before waiting for the conclusion of his trial.

8. Earlier ACCT procedures were not managed correctly. The Head of Safer Custody carried out the man's ACCT assessment interview and then, on his own, chaired the first ACCT review. On 30 December, a custodial manager closed the ACCT, again with no other staff present and with no healthcare input. At the time, he was held in the segregation unit, but there was no evidence of the exceptional reasons for this, as national instructions require for prisoners considered at risk of suicide and self-harm.

9. We are concerned that the nurses who found the man hanged did not go into his cell, although they had an emergency cell key, but waited until officers arrived. There was also a delay of approximately around five minutes in calling an emergency ambulance. While this did not affect the outcome for him, in other emergencies, such a delay could be critical.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
  - ACCT assessors do not chair the first ACCT case review;
  - Multidisciplinary case reviews are held with all relevant people involved in a prisoner's care;
  - Case reviews are held on the day they are scheduled or reasons given to explain the delay;
  - ACCTs should not be closed by one member of staff acting alone.

- The Governor and Head of Healthcare should ensure that staff open an ACCT whenever a prisoner has significant risk factors or potential triggers.

- The Governor should ensure that prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons, including at segregation reviews, to explain the exceptional circumstances. Prisoners on ACCT should have effective care plans to help prevent deterioration in mental health.

- The Governor and Head of Healthcare should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there are serious concerns about the health of a prisoner.

- The Governor and Head of Healthcare should ensure that all prison staff fully understand PSI 03/2013 and their responsibilities during medical emergencies and that the control room calls an ambulance as soon as an emergency medical code is received.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and inviting anyone with relevant information to contact him. One prisoner responded.

11. The investigator visited Hewell on 28 January and met the Governor, Head of Safer Custody, a representative from the Independent Monitoring Board and visited the man's cell. The investigator obtained copies of relevant extracts from the man's prison and medical records.

12. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

13. The investigator interviewed 14 members of staff and one prisoner. The clinical reviewer joined the investigator for six of the interviews with staff.

14. We informed HM Coroner for Worcester of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted the man's ex-partner, his named next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. The man's ex-partner asked a number of questions about what happened to the man, and the circumstances of his death, which we have taken into account and aimed to answer in this report.

Background Information

HMP Hewell

16. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. The man was at the Blakenhurst site which comprises six houseblocks, holding around 1100 men. Health services are provided by Worcestershire Health and Care NHS Trust.

Her Majesty's Inspectorate of Prisons

17. The last inspection of Hewell was in July 2014. Inspectors found that ACCT case reviews were often not multidisciplinary and healthcare staff had not attended any of the reviews they examined. Inspectors noted that many triggers for suicide and self-harm recorded in ACCT documents focused on past rather than future events that could prompt suicide or self-harm. Inspectors reported that relationships between prisoners and staff were generally good and in their survey, more prisoners than at comparable prisons said that most staff treated them with respect.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its 2013-2014 annual report, the IMB noted that, in recent years, there had been a significant increase in incidents of self-harm and bullying. They reported that staff were more vigilant, with increased numbers of prisoners supported for risk of suicide and self-harm.

Previous deaths at HMP Hewell

19. There have been 16 deaths at Hewell since 2012, including the man. Eight of these were the result of hanging, one of murder, five were from natural causes, one prisoner died shortly after release and one died from an overdose.

20. In two of the deaths from hanging, we found that ACCT reviews did not always include healthcare representatives. The same issue arose in this investigation.

21. In four deaths between June 2013 and November 2014, we found there were delays in calling an ambulance, which was also an issue in this investigation. We made recommendations about this in all four cases. The man's death occurred after Hewell told us that they had implemented our recommendations in those cases.

Assessment, care in custody and teamwork (ACCT)

22. 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.

23. 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.

24. 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.

Segregation Units

25. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The unit at Hewell is known as the care and separation unit and comprises 26 cells.

Key Events

26. In June 2014, the man was arrested. The man was held in police custody for several days and, on 3 July 2014, was remanded to HMP Birmingham. This was not his first time in prison. The Person Escort Record (PER) that accompanied him noted that he had threatened officers with violence and that he was schizophrenic.

27. At a reception health assessment when he arrived at Birmingham, the man said that he had previously been prescribed quetiapine for schizophrenia, but had stopped taking it in 2006 as he found vitamins more helpful. (There is no evidence that the man had been diagnosed with schizophrenia.) The man said he had no thoughts of suicide or self-harm.

28. Reception staff began suicide and self-harm prevention procedures (known as ACCT) for the man because of the seriousness of his charges. Officer A assessed the man as part of the ACCT procedures. The man said that he had never harmed himself in the past and that he had no current thoughts of suicide or self-harm. He said that he was not stressed about being in prison, but said he was angry and felt 'stitched up'. He told the officer that he had been diagnosed with paranoid schizophrenia, but no longer took medication for it. The man had no concerns about his mental health, but the officer advised that he should have a mental health assessment.

29. From reception, the man moved to the prison's segregation unit, until a decision was made about whether he should be regarded as a category A prisoner, the highest security category. (It was subsequently decided he was suitable for category B conditions). Later that evening, Nurse B assessed the man's suitability to be segregated. She noted some signs of mental illness: he spoke about sometimes seeing a shadow and as they talked, she noted he was looking at something to his side. He said that he heard voices telling him to do "nasty" things to people. She noted that his mood would shift from being lucid and calm to tearful. The nurse assessed the man as unfit to remain in the segregation unit. The man moved to the healthcare unit and staff were instructed to check him four times an hour.

30. On 4 July, the man told Dr A, a psychiatrist at Birmingham, that he had heard voices for several years, which told him to do both good and bad things. He said that friends had been telling him for years that they thought he suffered from paranoid schizophrenia. The man said that he had no thoughts of suicide or self-harm and had never tried to harm himself in the past. The doctor noted that the man's report of hearing voices appeared formulaic and that there were inconsistencies in his account of his history of mental ill health. The doctor decided that the man did not need any mental health input at that stage but that staff in the healthcare unit should continue to monitor him.

31. Nothing happened in the following weeks to cause staff to consider that the man was at risk of suicide and self-harm. On 14 July, staff closed the ACCT. On 17 July, he was discharged from healthcare and moved to D Wing, a standard prison wing. Soon after this he asked to move to G Wing, the vulnerable

prisoners' wing, because prisoners on D Wing had been asking about his alleged offences. The man moved to G Wing and was assessed as unsuitable to share a cell. He therefore had a single cell.

32. On the evening of 1 August, an officer from G Wing contacted a mental health nurse after the man said that he was hearing voices, could not cope anymore and was thinking of killing himself. The nurse advised the officer to open an ACCT and arranged for a mental health nurse to see the man the next day.

33. On 2 August, Officer C interviewed the man for an ACCT assessment. The man said that he was not suicidal, but said he was feeling extremely low and was worried that he might "snap" and harm himself in that split second.

34. That afternoon, the man told Nurse A, a mental health nurse, that he did not want to be on G Wing as he did not like hearing sex offenders talking about their offences. He said he wanted to move to the segregation unit or to a prison in London. The man said that he did not be monitored under ACCT procedures, as he had no thoughts of suicide or self-harm.

35. Supervising Officer (SO) A held an ACCT case review immediately after Nurse A had seen the man. The SO had decided to delay the review until the man had seen the nurse. Officer C briefed the SO before the review and two wing officers attended. The man said that he had no thoughts of suicide or self-harm but he wanted to go back to the healthcare unit: he said he was not prepared to move to a standard wing and did not want to have to listen to the complaints of prisoners on G Wing. The SO told the man that it was unlikely he would be able to go to the healthcare unit. The case review decided that the man was low risk of harming himself.

36. On 6 August, the man told Nurse B, a community psychiatric nurse, that he hated being on G Wing and had lied about his symptoms on 2 August in the hope of moving to healthcare. He laughed when he told her about this. He said that he had no thoughts of suicide or self-harm. Staff closed the ACCT later that day.

37. On 4 September, the man told Dr B, a consultant psychiatrist, that he wanted to move to the healthcare unit, as he did not like the other prisoners on G Wing. The doctor noted that he had found no evidence that the man had any mental health disorders and would not admit him to the healthcare unit. The doctor considered that the man was at low risk of suicide or self-harm.

38. On 10 November, the man was taken to Wolverhampton Crown Court for a remand hearing. From there, he was sent to HMP Hewell (the local prison serving the courts in Wolverhampton).

39. Nurse C saw the man for a reception health screen and noted that the man had strongly denied any past or current thoughts of suicide or self-harm. The man was still considered as too high a risk of violence to share a cell and he was held in Hewell's segregation unit because there were no other available single cells.

40. At a segregation review on 12 November, the man said that he felt he was under threat from other prisoners and he refused to leave the unit. The Head of Safer Custody said that the staff had tried to persuade the man to leave the segregation unit, but he would not. The man said other prisoners knew about his charges and he thought that made him vulnerable. The Head of Safer Custody said the man refused to go to the vulnerable prisoners unit. (The investigation found no evidence that any prisoners had made direct threats against the man, although there is some evidence that other prisoners in the segregation unit had taunted him by shouting things out across the unit.)

41. On 17 November, Nurse D saw the man at a segregation review. She noted that he was spending his time reading and writing letters to his family and told her he had no thoughts of suicide or self-harm. The nurse had no concerns about his mental health.

42. The man continued to refuse to move to a standard houseblock at Hewell. He said that he had problems with other prisoners because of the charges he was facing. The man asked to transfer back to Birmingham.

43. On 28 November, Officer D chaired another segregation review and noted that the officer had arranged for the man to transfer to Birmingham. He recorded that the man could not move anywhere else in Hewell because of "issues over his charges". He not record any more detail. Nurse D noted that the man was feeling low in mood about being in segregation but assessed him as fit to remain in the segregation unit.

44. While he was in the segregation unit, nurses, prison chaplains and managers saw the man each day as part of routine segregation room checks. No one noted any concerns until 3.00pm on 22 December, when Nurse D opened an ACCT after the man said he was thinking of hanging himself and had recently made a noose from his bedding. He said he was frustrated about being in the segregation unit with nothing to do, but he refused to move anywhere else in the prison. The man said he wanted to go back to a standard prison wing at Birmingham, where he could mix with other prisoners and have a television. (The man had a radio in his cell, but prisoners in the segregation unit do not usually have televisions.) The nurse noted that she thought the man's comments were because he was frustrated about his situation, rather than because he wanted to die.

45. A mental health nurse, Nurse E, saw the man to assess if he was fit to remain in segregation. She ticked a box on the assessment form to indicate that she did not think that the man's mental health would deteriorate significantly from being in segregation. She concluded he was fit to remain in the unit.

46. At 9.00pm that evening, the Head of Residence and Safety, who was responsible for the operation of the segregation unit, assessed the man as part of the ACCT process. The man said that he felt vulnerable because of his charges and he refused to leave the segregation unit. He said that he had made a number of previous requests for the man to transfer to Birmingham, but Birmingham had

said that the man would have to stay at Hewell until his trial was over. His trial was due to begin in three weeks.

47. The man again told the Head of Residence and Safety that he wanted to move back to Birmingham. He said that he did not want to die, but had made a noose the previous week. He said that he wanted to go to court to prove his innocence. The man told him that he could not live on a standard houseblock at Hewell because he had a large drug debt. (This was the first time the man had mentioned this and there was no evidence to suggest he was in debt.)

48. After the assessment interview, the Head of Residence and Safety held the first ACCT review alone with the man. He had phoned Nurse F, who was the only nurse on duty that evening, and recorded that no one from the healthcare department was available to attend the review that evening. He said that he held the review partly because the man was located in the segregation unit but also because the man was happy to engage with him. He did not record any exceptional reasons for holding a prisoner on an ACCT in the segregation unit. The Head of Resident and Safety assessed the man as at low risk of suicide or self-harm. He instructed staff to check the man twice an hour and record three conversations with him each day.

49. The Head of Resident and Safety made three entries in the man's ACCT caremap (plan of care, support and intervention). The first was that the man wanted to move from Hewell and that he would make a transfer request the next day. The second was that the man should be offered an integration plan, to help him move out of the segregation unit to a standard houseblock. The third entry was that he had referred the man to the mental health team for support and coping strategies. He noted that staff should hold a multidisciplinary ACCT review the next day, and a nurse should attend.

50. The man did not have an ACCT review on 23 December but on 24 December, SO B held a review with Nurse E present. The SO said that the man was in a good mood and spoke a little about his life before coming to prison. The man continued to refuse to move elsewhere in the prison and the SO wrote that the man was quite desperate to move to Birmingham. The man insisted that he would not harm himself and asked for the ACCT to be closed. The SO did not close the ACCT, as it had only been open for just two days, but he reduced the observations to three during the night with three conversations during the day. He set the next ACCT review for 29 December. The man also had a segregation review that day, chaired by Officer E. The officer did not record that the man was on an ACCT or any exceptional reasons why he should be in the segregation unit.

51. On 30 December, custodial manager A for the segregation unit, held an ACCT review on his own and closed the ACCT. (The review was again, one day later than initially planned.) The custodial manager said that the man was usually polite and compliant, but was frustrated because he had hoped to move to Birmingham. He said that he was surprised that the man had been monitored under ACCT procedures as he had never thought he was at risk of suicide or self-harm.

52. The custodial manager A said that he held the review on his own with the man as the segregation unit was busy that day. He said that, before the review, he had asked one of the segregation unit supervising officers, if he thought the ACCT could be closed and the supervising officer did not object. The man had said that he was not suicidal and he saw no point in being on an ACCT. The custodial manager said that he did not consider the man to be at risk of suicide and self-harm and he closed the ACCT. He did not consider getting any healthcare input at the time.

53. On 5 January 2015, the Head of Residence and Safety chaired a segregation review and noted that the man continued to refuse to leave the segregation unit; efforts to transfer him to Birmingham had been unsuccessful as Hewell was the appropriate prison for him to attend court for his trial. The Head of Residence and Safety referred the man to the mental health team as he had asked to see a psychiatrist. There was no reference at the review to the man being on an ACCT in the segregation unit.

54. On 6 January, Dr C, a consultant psychiatrist, saw the man in his cell in the segregation unit. The doctor found no sign of mental illness, such as signs of depression or psychosis. He noted that the man said he had no current thoughts of suicide. The man told him he was stressed as other prisoners were taunting him about his alleged offences and he was under threat because of his drug connections. The doctor said that he heard other prisoners shouting derogatory comments to the man while he was speaking to him. The doctor noted that if there was any deterioration in the man's mental health, staff should consider transferring him to the healthcare unit.

55. Nurse G said that healthcare staff discussed the man after Dr C had seen him and decided that it would be better for him to move to the healthcare unit as this would be a more suitable and supportive location for him with his trial soon to start. The next day, he moved to a single cell in the healthcare unit. (All of the cells in the healthcare unit at Hewell are single cells).

56. On 9 January, Nurse G noted that that the man had seemed settled, had spent time out of his cell and had interacted appropriately with staff and other prisoners.

57. On 10 January, Dr C reviewed the man and thought he appeared much more settled than when he had seen him in the segregation unit on 6 January. He found no signs of mental illness, but noted that the man appeared to be stressed about his forthcoming trial. The man asked for sleeping tablets and the doctor prescribed a 28 day course of zopiclone. The doctor noted that the man should remain in the healthcare unit until the end of his trial.

58. On 13 January, Nurse G recorded that the mental health multidisciplinary team had discussed the man again that day and agreed that he might be at risk of harming himself, due to the stress of his court case. She noted that staff needed to be vigilant and open an ACCT if they considered it appropriate.

59. On 16 January, the man went to court for a remand hearing. When he got back to the prison that evening, he told Nurse G that he had had a very stressful day. He agreed to meet her over the weekend to discuss his care and whether there was anything more the healthcare team could do for him.

60. On Sunday 18 January, Nurse G wrote in the man's records that he had interacted appropriately with staff and prisoners and appeared settled in his mood and mental state. She noted that he did not want to talk about how he was, but he was happy to have a general chat. The man's trial started the next day, Monday 19 January.

61. When he returned from court on the evening of 19 January, the man was annoyed because there was no food or tobacco waiting for him, which he said staff had promised. He said he would barricade himself in his cell and cut himself. One of the night officers spoke to him and calmed him down and the man said that his only reason for making the threat was to get some tobacco.

62. On 20 January, the mental health multidisciplinary team discussed the man and whether he needed to be supported by ACCT procedures. The multidisciplinary team noted that, at that time, the man seemed settled, but he sometimes seemed stressed. They noted in the man's medical record that staff needed to take into account any alerts from court staff and that they should open an ACCT if the man was found guilty. Dr C said that he did not see the man that day: he waited in the prison until about 7.00pm, but the man had still not returned from court.

63. The only other substantial entry in the man's records for the first four days of his trial was an entry on 21 January, when he complained to a nurse that he was unable to shower, as he was leaving for court too early in the morning and returning too late in the evening.

64. Prisoner B told the investigator that he met the man for the first time when they went to court together on Friday 23 January. While waiting to be searched in the reception area before they left, they had spoken to each other about the charges they were facing. The prisoner said that, at around lunchtime, the man had had to use the court toilet. Just before he went into the toilet, the prisoner heard the man say something like, "I'd rather die than face her". The prisoner said that he thought the man was referring to someone in the public gallery. He said that the man stayed in the toilet for a long time. Both of their cases were adjourned in the early afternoon and they travelled back to the prison together. (Newspaper articles after the man's death reported that his cross-examination was due to begin that day. We do not know whether the prosecution had begun to question him before his case was adjourned for the day). When they returned to Hewell, the prisoner asked the man if he was feeling better and the man said he was. The prisoner did not see the man again.

65. The man was booked back in to Hewell at 3.30pm. The Head of Residence and Safety said that he was walking through reception and saw the man in one of the holding cells. He said he had asked the man how he was feeling, and the man had said that he was okay. The Head of Residence asked one of the reception officers, Officer F, to take the man back to his cell in the healthcare unit. Officer F

told the investigator that it took only about 40 seconds for them to walk to the healthcare unit and he had no conversation with the man in that brief period.

66. Nurse H noted that the man's court case had been adjourned that afternoon as he had been unwell and the court needed a doctor to confirm that he would be fit to attend on Monday.

67. That evening, the man told Nurse H that he was finding it hard to cope and sometimes felt like he was losing his mind. The nurse said that the man indicated that he was not guilty of the offences and said there were "always two sides to a story". The nurse noted that she had told the man that he could speak to staff, who would support him over the weekend. She recorded that the man had said he had no thoughts of suicide or self-harm.

68. On the morning of Saturday 24 January, Dr D assessed the man's fitness to attend court on Monday 26 January. The doctor noted that the man's trial had been adjourned because he had had diarrhoea and a headache. He noted that both conditions were settling and he expected the man to be well by Monday. The doctor prescribed paracetamol to be given when required and an anti-diarrhoea tablet, also when required. The doctor did not record anything about the man's mental health. He told the investigator that he had considered the man's mental health during the consultation and did not have any concerns.

69. Nurse G said that she had sat in on the man's consultation with Dr D. The man was annoyed about being woken to see the doctor and went back to sleep afterwards. She went to his cell several times during the day to speak to him but it was after 6.00pm before they spoke. By this time, all of the prisoners in the healthcare unit were locked in their cells and so she was only able to speak to him through the hatch in his door. The man spoke to her about his past and said that his parents had died when he was young. He said that he had lost contact with his child and the child's mother. The man said that he would not "do a life sentence" but Nurse G noted that he said he did not have any thoughts of suicide or self-harm. She told the investigator that she thought the man might have been at high risk of suicide if he was ultimately found guilty, but she did not think he would be at risk before then.

70. A healthcare assistant, A, was on duty in the healthcare unit on the night of 24 January. The man pressed his cell bell at around 8.20pm to ask for his zopiclone sleeping tablet. The healthcare assistant told him that the nurse, Nurse F, was dispensing medication on the prison wings and that she would give him his medication when she came back to the healthcare unit. The man accepted the explanation. The healthcare assistant said he had apologised to her for being abusive the night before, when she had also told him that he would have to wait for the nurse to bring his medication.

71. Around 20 minutes later, Nurse F gave the man his zopiclone. She told the investigator that she asked the man if he was okay and he had said he was. She had no concerns about him at the time. That was the last time the man was seen alive.

72. According to CCTV footage, at 6.09am on 25 January, the healthcare assistant A began checking the cells. She reached the man's cell at 6.10am, and saw him hanging from a ligature made from a shoelace and a sheet intertwined and attached to the light fitting. The healthcare assistant shouted to an officer who was at a nearby cell constantly supervising another prisoner who had been identified as at high risk of suicide. She said that she was so shocked that she could not speak properly so the officer radioed a code blue medical emergency, which should alert the control room to call an ambulance automatically. She ran to the nurses' office to tell Nurse F to bring an emergency bag. The healthcare assistant said that she checked with Nurse F that they needed an ambulance and she then radioed the control room to pass on this message. (Records show there was a delay of around five minutes between the initial code blue alarm and an ambulance being called.)

73. Nurse F said that she heard healthcare assistant, A, shouting and heard the code blue call on her radio. When she got to the man's cell, she looked in and realised immediately that he was dead. She said his feet were off the ground and it was clear that he was dead because of his skin colour and the position of his neck. She brought emergency equipment. Although she and the healthcare assistant carried cell keys in a sealed pouch for use in an emergency they did not go into the cell, but waited for officers to arrive, as they had been instructed to do.

74. Custodial manager, B, was in charge of the prison that night arrived in the healthcare unit at just after 6.13am, in response to the emergency call. He did not have a cell key but the healthcare assistant A gave him her key from the sealed pouch. The custodial manager went into the cell and supported the man's body. Officer, I, arrived and cut the ligature. Custodial manager, B, thought that rigor mortis might have started as the man's body did not move as he lowered him to the ground.

75. Nurse F examined the man and found no pulse or other signs of life. She concluded that the man had died and decided that it would not be appropriate to try to resuscitate him as it was apparent that he had been dead for some time.

Contact with the man's family

76. The man had not initially named a next of kin, but when his last ACCT was opened he named an ex-partner, who was the mother of his child. He left a brief note to her in his cell. He also left a note for his current partner and the prison asked the local police to inform her of his death. The man's ex-partner lived in Sussex and the prison asked the police to break the news to her. The prison contributed towards the cost of the man's funeral in line with national Prison Service instructions.

Support for staff and prisoners

77. Hewell's Head of Reducing Reoffending, debriefed the staff involved in the emergency response and informed them of the support available from the care team. Staff reviewed all prisoners being managed under ACCT procedures in case they had been affected by the man's death.

Post-mortem report

78. The man's cause of death was given as hanging. A toxicology report showed the presence of prescribed medicines only in his body.

Findings

Assessing the man's risk of suicide and self-harm

79. The man was briefly monitored under ACCT procedures three times; twice at Birmingham and once at Hewell. Each time, the man was considered at low risk of suicide and self-harm. However, in January 2015, as the man's trial approached, healthcare staff began to consider that the man might be at risk of suicide or self-harm due to the stress of the case. They did not begin ACCT procedures but advised vigilance and that staff should open an ACCT if necessary.

80. The man's trial began on 19 January. Again, healthcare staff considered whether to begin ACCT procedures. A multidisciplinary mental health team agreed that the man would be at a higher risk of suicide and self-harm if he was found guilty of the murders. They agreed that an ACCT should be opened if and when that happened. In a Learning Lessons Bulletin published in April 2014, about risk factors in self-inflicted deaths, we said:

> "An ACCT can be opened at any point when a risk is identified … An important part of the ACCT planning process is to identify events … which could increase the risk of the prisoner harming [himself] … triggers … should not be viewed as static, as they can often change, depending on other factors in the prisoner's life …"

81. We note that the mental health team carefully considered whether to open an ACCT before and during the man's trial and it is evident that they identified that he was at some degree of risk of suicide and self-harm. We recognise that this was a matter of judgement, and it is easy with the benefit of hindsight to spot risk. However, staff themselves had concerns about his stress and Prison Service Instruction (PSI) 64/2011, which covers safer custody and ACCT procedures, specifically identifies court appearances, especially the start if trial and sentencing, as potential triggers for suicide. The man's stress was particularly evident on Friday 23 January, when he was ill and unable to face cross-examination.

82. Although the staff had agreed that they would open an ACCT if he was found guilty of the charges against him, neither prison nor healthcare staff were with the man in court. He was facing heinous charges of murdering two elderly people. The staff did not know how the trial was progressing, or that the man might conclude that he was likely to be convicted, before a verdict was reached. In the circumstances, we consider it would have been prudent to open an ACCT during the man's trial and carefully monitor him. We understand that since the man's death healthcare staff monitor all patients in the healthcare unit at least once an hour. We welcome this, but consider there is also a need to identify and monitor prisoners at particular risk, through ACCT procedures. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff open an ACCT whenever a prisoner has significant risk factors or triggers for suicide and self-harm irrespective of his stated intentions.

ACCT procedures

83. The man was not being managed under ACCT procedures at the time of his death. However, we had some concerns about how effectively the ACCT process was managed at Hewell, which was not always in line with Prison Service national instructions. On 22 December, after Nurse D opened an ACCT, and the Head of Safer Custody, assessed the man as part of the ACCT process and then held the first case review.

84. Prison Service Instruction (PSI) 64/2011, which covers ACCT procedures, explains the distinct responsibilities of the ACCT assessor and the chair of the first case review. The PSI states that the ACCT assessor must attend the first case review if possible, but must not chair the review. The PSI also directs that the first case review must be multidisciplinary, with at least a member of healthcare staff present. Although the Head of Safer Custody had spoken to a nurse before the review, there was no member of healthcare staff at the review, as the national instruction requires.

85. After the case review on 22 December, the Head of Safer Custody set the next case review for 23 December, but this did not happen. There was no record why. A supervising officer chaired the review on 24 December and a nurse attended. The man's next review was set for 29 December, but it did not take place until 30 December. Again, there was no reason given for the delay.

86. Custodial manager, A, closed the man's ACCT at the review on 30 December. He held the review by himself with no other member of staff present. There is a requirement that ACCT reviews must be multi-disciplinary where possible and PSI 64/2011 refers to the case review team. It is particularly poor practice that a member of staff should close an ACCT by himself with no input from other staff at the review. The PSI states that an ACCT can be closed only if the case review 'team' judges that it is safe to do so. One member of staff acting in isolation cannot constitute a team.

87. The investigation has identified a number of areas for improvement in the management of ACCT procedures and the assessment of the risk of suicide and self-harm. We make the following recommendation:

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

- **ACCT assessors do not chair the first ACCT case review;**
- **Multidisciplinary case reviews are held with all relevant people involved in a prisoner's care;**
- **Case reviews are held on the day they are scheduled or reasons given to explain the delay;**
- **ACCTs should not be closed by one member of staff acting alone.**

Segregation

88. On 22 December, the man was in the segregation unit and said he was thinking of hanging himself and had recently made a noose from bedding. An ACCT was opened, but the man did not have a mental health assessment within 24 hours of the ACCT being opened, as we would expect for a prisoner in segregation.

89. Prison Service Order (PSO) 1700, which governs segregation processes, makes clear that prisoners in segregation units are usually those who are most difficult and often those who are most vulnerable. PSO 1700 requires that prisoners on an open ACCT should only remain in segregation under exceptional circumstances such as them being a risk to others, where no other location is appropriate and where all other options have been tried or are considered inappropriate. It says that particular care should be given to authorising continued segregation of a prisoner on an open ACCT and that continued segregation should occur only in exceptional circumstances and an ACCT case review must take place at the same time as the segregation review board.

90. PSI 64/2011 - Safer Custody, also requires that:

"Prisoners on open ACCT plans must only be located or retained in Segregation Units only in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include others options that were considered but discounted."

91. There is no evidence that any member of staff considered whether there were exceptional reasons to hold the man in the segregation unit, after the ACCT was opened. Nothing was recorded in the ACCT document as the PSI requires and there was nothing in his segregation review records. In June 2015, we issued a learning lessons bulletin about the particular vulnerabilities of prisoners in segregation units and the need to ensure that prison staff followed the safeguards designed to protect such prisoners. While staff eventually moved the man from the segregation unit, it is a concern that staff did not seem to recognise the exceptional position of segregating a prisoner on an ACCT and did not follow the expected safeguarding procedures. We make the following recommendation:

The Governor should ensure that prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons, including at segregation reviews, to explain the exceptional circumstances. Segregated prisoners on an ACCT should have an urgent mental health assessment and effective care plans to help prevent deterioration in mental health.

Emergency response

92. Nurse F and health care assistant A were both carrying a cell key in a sealed pouch, but said they had been instructed not enter a cell at night without an officer present. If staff are given cell keys for use in an emergency, we would expect them to use them, subject to a risk assessment. In this case, the man was already dead but in other cases a quick response to a prisoner hanging, could save a life. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there are serious concerns about the health of a prisoner.

93. Prison Service Instruction (PSI) 03/2013 requires that prisons have a medical emergency response code protocol to ensure that an ambulance is called automatically in a life-threatening situation. Hewell's local policy, published on 18 June 2013, is in line with the PSI and requires control room staff to call an ambulance as soon as a medical emergency code is received. However, there was a five minute delay before an ambulance was called. Health care assistant A, first checked with Nurse F and then radioed the control room to confirm paramedics were needed. Custodial manager, B, confirmed said that this was the process followed at Hewell, although it was contrary to the policy.

94. The delay in calling an ambulance made no difference in the man's case, but in other emergencies any delay could be crucial. Previous recommendations, and their own local policy, have not changed staff practice at Hewell, and it is important that prison managers make sure that all staff understand the need to follow the expected emergency procedures. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prison staff fully understand PSI 03/2013 and their responsibilities during medical emergencies and that the control room calls an ambulance as soon as an emergency medical code is received.

Clinical care

95. The clinical reviewer found that the man received prompt treatment for physical or mental health problems while at Hewell. He considered the weekly multidisciplinary team meeting to be an example of good practice. However, he was concerned that the man was not checked during the night of 24/25 January. He recommended that all prisoners in the healthcare unit should be checked hourly through the night and we understand that this is now done.