

**Investigation into the circumstances surrounding the
death of a man
at HMP Manchester in June 2010**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2011

This is the report of an investigation into the circumstances of the death of a 29 year old man who was found hanging in his cell in HMP Manchester in June 2010.

I extend my sincere condolences to the man's family and friends for their loss. I apologise for the delay in issuing this report and for any additional distress this may have caused.

The investigation was carried out by my colleague. A review of the man's clinical care was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful to him for this review. I should like to thank Manchester's Governor and his staff for their co-operation.

The man had been at HMP Forest Bank for almost a year by early May 2010 when he escaped from prison. He remained at liberty for only a few weeks before being recaptured and taken into HMP Manchester. He was sentenced to nine and a half years imprisonment and categorised as a Category A prisoner as he was deemed to be at high risk of attempting to escape.

For much of his time in Manchester, the man received additional support and monitoring by staff as he was recognised to be a risk to himself. He was experiencing marital difficulties and described this as one of the factors causing him distress. These support and monitoring measures were still in place when he died, less than a month after his arrival into Manchester.

I make three recommendations. One is about improving support for Category A prisoners. Another is about the need for staff to record significant conversations with prisoners. The third is about night time checks on prisoners on the Category A wing. I also commend two members of staff for the way they dealt with the man's family after his death. In addition to my recommendations, the clinical reviewer makes 10 recommendations (as well as reiterating a recommendation made in my report).

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

Thea Walton
Acting Deputy Ombudsman

December 2011

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SUMMARY

The man was a 29 years old and was found hanging in his single cell in HMP Manchester in June 2010. He had first arrived in custody at HMP Forest Bank in May 2009 having been charged with offences related to motor car fraud. He was still at Forest Bank in April 2010 when he was found guilty of the offences with which he had been charged. He escaped from custody a few days later.

The man was re-arrested at the end of May 2010 and brought into HMP Manchester. He was brought into the prison via Crown Court where he was sentenced to nine and a half years imprisonment. He reported to a reception nurse that he felt depressed about being back in custody, and also about the sentence he had just received. He was unhappy about the prospect of a further sentence, the recent suicide of his sister and also about missing his wife and children. Reception staff opened an Assessment, Care in Custody and Teamwork (ACCT¹) plan and he was admitted to the prison's healthcare unit where he would have enhanced support from staff.

The following day, the man reported feeling very much better. He said that his low mood the previous day was due to the upsetting events of that day. He denied having any suicidal ideas and asked to move out of healthcare. Within a few days the ACCT support was closed and he moved to E wing inner. (E wing inner holds Manchester's category A prisoners – the man was both a category A prisoner and an escape-list prisoner.)

A second ACCT plan was put in place a few days later when the man reported having suicidal thoughts because of marital difficulties. It remained open for the rest of his life. The case reviews reflected some fluctuation in his mood and he spent some time under constant supervision² in healthcare.

The man's mood appeared to begin to settle from around 13 June and he returned to E wing. He still reported marital difficulties and was also anxious about waiting for other family members to be cleared for visiting (more stringent security clearance measures apply to visitors to category A and e-list prisoners). His brother was imprisoned on another wing and, after his death, reported that he had not been allowed to visit either. All his telephone contacts had to be security cleared and these checks were completed within a few days of his arrival into Manchester.

By 23 June, the night time ACCT checks had been reduced to once an hour. At the 8.30pm check, the man seemed well and was watching television. When the officer made the next check an hour later, the man was not in the main cell area. The officer tapped on the door but, receiving no response, assumed that he was using the toilet. He checked the other prisoners before returning to the

¹ ACCT (Assessment, Care in Custody and Teamwork) is the process used for monitoring and supporting prisoners deemed at risk of self-harm or suicide.

² Constant supervision is the most intense form of support for a prisoner at risk of suicide or self harm. A member of staff provided one-to-one supervision of the prisoner at all times of the night and day.

cell a few minutes later. The man was still out of sight and so the officer summoned assistance. When staff went into the cell, the man was found hanging in the toilet area. Staff attempted to resuscitate him and an ambulance was summoned. Unfortunately, their efforts at resuscitation were unsuccessful.

I make three recommendations. One is about improving support for E wing prisoners, who, as Category A prisoners, do not have access to all the support mechanisms available to other prisoners. Another concerns the need for staff to record any significant conversations with prisoners to ensure that other staff members are aware of them. The third is about night time checks on E wing. I also commend two members of staff for the way they communicated with the man's family after his death. The clinical reviewer makes 10 further recommendations (as well as reiterating a recommendation made in my report).

THE INVESTIGATION PROCESS

1. The investigator in this case first visited HMP Manchester on 1 July 2010 when he met various staff from the prison's safer custody team, two of the prison's family liaison officers and a representative from the Prison Officers' Association. He explained the nature and scope of the investigation.
2. The investigator visited the man's cell and was shown around the wing. He was given a copy of the man's prison and health records. Notices were issued to staff and prisoners informing them about the investigation and inviting them to contact the investigator if they wished to be involved in the investigation.
3. The investigator subsequently interviewed 16 members of staff and one prisoner. No other prisoners came forward in response to the notices about the man's death.
4. The investigator contacted the Coroner's officer and a copy of this report will be sent to the Coroner to assist his enquiries.
5. A clinical reviewer carried out a review of the man's clinical care and treatment on behalf of the local Primary Care Trust.
6. The Ombudsman's Senior Family Liaison Officer wrote to the man's wife, mother and father to inform them of the Ombudsman's role and responsibility and to invite them to raise any concerns to be explored as part of this investigation. The family raised no specific issues but did express an interest in receiving my report. I hope that the report offers further explanation into the events leading to the man's death.
7. In accordance with the Prison and Probation Ombudsman's operational terms of reference, an advance draft of this report was disclosed to the services in remit due to criticism made of the actions of a member of staff. This is referred to again later on in this report which has now been fully disclosed to all parties.

HMP MANCHESTER

8. HMP Manchester is a category A (high security estate) prison located in the centre of the city. In addition to its function as a category A prison, Manchester also operates as a local prison serving the courts of the Greater Manchester area. It holds up to 1,269 adult male prisoners on remand, convicted and sentenced. The E wing inner section operates as the self-contained unit for up to 53 category A and escape-list prisoners.
9. The National Offender Management Service (NOMS) publishes quarterly performance ratings of prisons in England and Wales, with each prison being assessed across a number of set indicators. Throughout the 2009/2010 operational year Manchester's performance was deemed "good" (this is the second highest possible rating).
10. HM Chief Inspector of Prisons (HMCIP) last carried out a full announced inspection of Manchester in July 2009. In the introduction to the inspection report the Chief Inspector wrote that:

"Unlike some of the other core locals, Manchester has always tried to ensure that it can meet the needs of the great majority of its prisoners, who could be found in any large local prison, while ensuring the security necessary for category A prisoners. This inspection found that still to be the case. The fact that category A prisoners were held on a separate landing meant that security arrangements for the rest of the prison did not intrude unduly on the regime. This did, however, create a very claustrophobic and restricted regime on the category A landing."
11. In considering support for prisoners at potential risk of self-harm, the Chief Inspector found that:

"The comprehensive suicide prevention and self-harm strategy adopted a holistic approach to support ... assessment, care in custody and teamwork (ACCT) documents ... were reasonably well completed, but case reviews were not sufficiently multi-disciplinary ..."
12. Each prison in England and Wales is also monitored by an Independent Monitoring Board (IMB) formed of volunteers from the local community. IMB members have full access to every prisoner and all parts of the prison. The Board produces an annual report, with the most recent available for Manchester covering the period 1 March 2009 to 28 February 2010. The IMB commented in its report that staff at Manchester had continued to meet targets and continued to maintain performance expectations to a high standard despite the backdrop of efficiency savings which had been required in recent years.
13. There have been 18 previous self-inflicted deaths at Manchester since the Ombudsman began investigating all deaths in prisons in 2004. I have found no particular similarities between the circumstances of those deaths

and that of the man's. None of the previous deaths were of category A prisoners.

KEY FINDINGS

14. The man was born in Rochdale in May 1981. He went to a school in Cheshire but reported that he missed a lot of schooling and he left without gaining qualifications. After finishing school he worked with his father in labouring and landscaping jobs. He married at a young age and he and his wife had three children and settled in a home in Stockport.
15. On 7 May 2009, the man was arrested and charged with several offences of “conspiracy to convert criminal property” (the sale of stolen motor vehicles). He was also charged with absconding from custody (he had twice absconded from custody in 2002 while serving a nine month sentence).
16. Having spent two days in police custody, the man was taken to HMP Forest Bank in Manchester on 9 May. The prisoner reception process at Forest Bank included an assessment of his mental and physical health during which he reported no health problems. The following section of the assessment form dealt with self-harming thoughts and behaviour. In answer to several questions in that section he reported having no previous history or current thoughts of acts of self-harm. The final section of the assessment form was for the member of staff to make their own assessment of his demeanour. He was described as “cheerful, co-operative and polite”.
17. Within a few days of arriving at Forest Bank the man started working as a wing cleaner. The entries in his records showed that he worked hard and was polite and conformed to the rules. In due course he gained enhanced privilege status. (Prisons provide a system of privileges that can be granted to prisoners in addition to their minimum entitlement. This is the Incentives and Earned Privileges scheme when privileges above the minimum are earned by prisoners through good behaviour and performance in work or education.)
18. In the middle of March 2010, the man’s sister committed suicide. He had hoped to attend the funeral but was unable to do so as, on the day, Forest Bank did not have sufficient staff available to escort him.
19. The man’s trial had also commenced in March 2010 at Crown Court. At the end of April he was found guilty on various counts of fraud and remanded back into custody pending sentencing.
20. At just after midnight on 2 May, the man called for help saying that he had injured his ear. He was bleeding profusely so staff called an ambulance for him to be transferred to outside hospital. While on the way to hospital, the ambulance was intercepted by a masked gang who aided the man’s escape.
21. The man remained at liberty for three weeks before being re-arrested in the early hours of 28 May at an address near Southport in Merseyside.

He was taken to a police station in Manchester where he was assessed by a mental health nurse who thought that he seemed depressed. He was taken from the police station to Crown Court where he was sentenced to nine and a half years imprisonment further to his conviction the previous month. From court, he was then taken to HMP Manchester where he arrived at around 7.00pm.

22. When a prisoner is transferred between prisons or from one agency to another, staff must complete a person escort record (PER) form on which they list potential risk factors. In the man's case the escorting staff recorded that he said he had suicidal tendencies. Upon his arrival at Manchester, the reception officer noted the entry on his PER form. Based on that information, as well as the officer's own observation of him appearing to be "very low in mood", the officer put ACCT support measures in place.
23. The man was also assessed by a reception nurse who noted:

"... very upset and tearful during interview. Sentenced to 9 [years] 6 [months] doesn't feel he will cope. States couldn't cope with 12 [months] remand at Forest Bank. States feels very depressed at thought of serving sentence, missing his children and wife ... Informed will be going back to [court] again and will be getting another 4 [years] on top of his sentence due to his escape from Forest Bank. Informed also that his sister hanged herself 3 weeks ago and he is not coping with this ..."
24. Following the reception process the man was moved to the prison's healthcare unit where a higher level of support could be provided. Later that evening one of the healthcare nurses made a note in his ACCT plan and clinical record of a lengthy conversation. The man repeated the information he gave earlier about the prospect of a four year sentence on top of the nine and a half year sentence he was already serving. He told the nurse that he did not feel that he would be able to cope with such a long sentence. When the nurse asked him if he had any plans to harm himself, he replied that he did not want to kill himself. The nurse noted that she encouraged him to focus on the positive aspects of his life.
25. Because the man had escaped from Forest Bank, he was classified as an escape-list (e-list) prisoner, meaning a prisoner thought liable to try to escape. He was also classified as a high-risk category A prisoner which was linked to his escape, which was violent. Being an e-list prisoner and/or a category A prisoner has a number of implications. At Manchester, category A prisoners are held on E wing and so this was the only wing where he could be held apart from healthcare. Another impact was that all of his telephone calls would be monitored. In addition, more comprehensive security checks were required before he could be allowed any visitors. Pending completion of these security checks, category A prisoners can be allowed closed visits with immediate family only at the

discretion of the Governor. (A closed visit is when the prisoner and visitor are separated by a glass partition and cannot make physical contact.)

26. In the late morning of 29 May, the man had an ACCT assessment interview with a senior nurse. (The ACCT process includes a detailed assessment interview with a trained ACCT assessor to take place within 24 hours of the plan being put in place.) The senior nurse told my investigator that her general practice is to carry out ACCT assessment interviews on the second day after the person's arrival into prison. This allows them to "have a sleep and to settle down a little". The senior nurse said that when she met the man he said that he no longer needed additional support. He said he had been upset the day before but this was because he had only just been brought back into custody and had just been sentenced. He said that he felt much better and had no intention of harming himself. He also asked to move to a main prison wing as he felt that being in healthcare was unhelpful.
27. The man spoke about his escape from custody, acknowledging that cutting his ear had been part of the plan. His sister had committed suicide a few weeks before but he had not been able to go to the funeral and so he wanted to spend time with his family. The senior nurse told my investigator that the assessment lasted around 30 to 45 minutes. He made good eye contact and appeared open and honest with the things he was saying.
28. An ACCT case review was held shortly after the assessment interview. The senior nurse chaired the review and she was accompanied by a Senior Officer (SO). The senior nurse told my investigator that the review did not last long and that she and her colleague were in agreement that the ACCT should be closed. She made an entry on the ACCT record to say that, due to his demeanour, the support was to come to an end. She also noted that he understood the support network available within the prison and indicated that he would not hesitate to access that support if needed. Not long afterwards he was discharged from healthcare to E wing (the category A wing).
29. On 2 June, the man made several telephone calls to his family which were monitored by Manchester's security office. The security office sent a report to E wing to say that the man had sounded unstable in some of the conversations. On the same day, his mother telephoned the prison to say that she was concerned about her son's wellbeing. A senior officer made an entry in the man's records saying that they had spoken and, although the man was "fed up", he was getting on well with a number of the prisoners and understood that support was available if he needed it. The senior officer concluded that there was no need to re-open the ACCT plan.
30. A standard ACCT post closure review was held on 3 June. Staff members at the review included one of the senior officers from the category A unit (the first SO) and a Registered Mental Nurse from the mental health in-reach team and employed by Manchester Mental Health and Social Care

Trust (the first RMN). The man said that he felt better about his situation and some of his initial concerns had now been resolved, for instance being able to telephone his family. He also said that he felt more settled on the wing and knew some of the other prisoners there. The review panel were content that the ACCT plan should remain closed.

31. Another of the senior officers from the category A unit (the second SO) told my investigator that the man had two great concerns at this time. One concern was that, being an e-list prisoner, he was still waiting for his friends and family to be security cleared to allow them to visit. However, his major concern was his relationship with his wife.
32. On the morning of 5 June, the first SO was told that the man wanted to speak with him. The man came to the wing office and said that he could not cope, his wife did not want anything to do with him and he was contemplating taking his life. The first SO reminded him of reasons for optimism, such as his children, but he persisted in saying that he wanted to harm himself. The first SO re-opened the ACCT plan and called for an ACCT assessor to come to see him.
33. The first Officer told my investigator that she is a trained ACCT assessor. Before going to E wing, she spoke briefly with the first SO by telephone. He told her that there was an immediate concern that the man might harm himself. Based on what he had told her, the officer asked the second RMN to assist with the ACCT immediate needs assessment in case he needed to be moved to a safer cell (a cell designed to minimise as far as possible any opportunities for self-harm through the use of ligatures). The first officer and second RMN went to E wing.
34. The first SO and the man were in the wing office talking when the other staff arrived. The first officer told my investigator that she explained the ACCT process to the man and also clarified whether he wanted the first SO to leave the room. The man said that he was content for both the first SO and the second RMN to remain. He spoke about the issues in his life which included his sister's suicide, his escape from Forest Bank and the problems in his marriage. He said that he felt better having spoken with staff, but found that the most difficult part of the day was after 5.00pm when he was alone to think about his issues. He mentioned feeling isolated at this time of day.
35. Towards the end of the conversation, the first officer asked the man whether he was still thinking of harming himself. He denied having such thoughts but asked whether he could have a cell-mate. He was told that he would not be allowed to share a cell while he remained a category A and e-list prisoner. He agreed to approach staff for support if necessary, or use the Samaritans telephone line.
36. The first officer said that the ACCT assessment interview "merged" into an ACCT case review with the same four people remaining in the room. She said that the entire process lasted around an hour and it seemed to work

well in terms of how open and co-operative the man had been. (The ACCT process includes the setting of an appropriate level of interaction that staff should have with the prisoner and in this case they were set at three conversations during the day with hourly observations at night time.)

37. The first RMN reviewed the man on E wing on 7 June when she observed that his mood appeared to be low. He mentioned having suicidal thoughts, which he said escalated when he had contact with his wife. However, he denied any intent to act on those thoughts and said that he spoke to staff when there was a crisis. He also agreed to stop attempting to contact his wife for a period of time to allow the situation with her to settle. He mentioned having difficulty with his sleep pattern and the first RMN noted that she would ask Manchester's psychiatrist to consider prescribing a sedative. The psychiatrist prescribed a sedative, Zopiclone, that day. This was a seven day course of one 3.75 milligram tablet once per day, to be taken in the evening.
38. The man's next ACCT case review was held in the early afternoon of 8 June, chaired by the first SO. The man said that his wife was insistent that their marriage was over and he saw "no light at the end of the tunnel". The notes of the review included him again agreeing that he needed "to give it time for things to settle". The second RMN was also at the review and she made an entry in the man's clinical records that he reported being in a slightly better mood than when the ACCT plan was opened.
39. The second SO was also at the review on 8 June when the man spoke of his concern over his relationship with his wife. Everyone present told him that he should "take one day at a time", which he accepted. The second SO said that there was nothing about the man's demeanour that day to cause him to feel overly concerned for his welfare.
40. In addition to review meetings, an additional element of the ACCT process is the construction of a CAREMAP. This should be a collaborative process setting out each of the issues that are of concern to the prisoner with a plan for how the issues will be addressed. In the man's case issues on his CAREMAP included contact with his family, to be removed from the e-list and to deal with his threats (or thoughts) of self-harm.
41. At a consultation on 9 June with Manchester's principal doctor, the man reported having been in a low mood for the past three weeks. He repeated that the contributory factors were his sister's suicide, his sentencing, escape and recapture, his expectation of an additional sentence for the escape, and his marital difficulties. The doctor prescribed a 28 day course of Citalopram Hydrobromide, an antidepressant medication. He also prescribed a seven day course of 7.5 milligrams of Zopiclone to be given at night. This was to be in addition to the day time prescription written two days earlier. (The doctor's entry in the prescription chart was ambiguous and the first dose of the night time Zopiclone was given to the man that afternoon. The following day the doctor rewrote the prescription to make it clear that the medication was to be given at night.)

42. On the morning of 10 June, the second SO chaired an unplanned, urgent ACCT review. It was arranged at short notice following a report from the prison's security unit that the man had commented in a telephone call to his mother that if "things didn't go his way that day he would harm himself". The second SO told my investigator that the man's greatest concern was that his wife was not answering his telephone calls. He reminded him about the support that was available, that is the prisoner Listeners³, the Samaritans and wing staff. After the review the second SO contacted the mental health in-reach team to ask them to come to see the man. (This resulted in him being discussed in the clinical team meeting leading to him being admitted to healthcare.)
43. That afternoon the man had a telephone conversation with his wife during which they both became extremely distressed and he said that he intended to take his life.
44. Manchester's Safer Custody Manager was informed of the man's threats of suicide by the security unit and so he went to listen to a recording of the telephone calls. He judged that the man was at high risk of harming himself. He explained to my investigator that the Safer Custody Team's role includes co-ordinating the administrative aspects of the ACCT process. The team also provide specific advice and guidance to staff but do not generally become involved in managing prisoners which is the role of wing staff.
45. On this occasion the Safer Custody Manager decided to have a closer involvement and he attended the multi-disciplinary ACCT review for the man that afternoon. The panel comprised a psychiatrist, three mental health nurses, two discipline officers, the Safer Custody Manager and the man. The Safer Custody Manager introduced himself to the man as the Safer Custody Manager and asked him whether he was comfortable with the number of people at the review. He replied that he was comfortable with the number.
46. The review was chaired by a Registered General Nurse (RGN). The RGN told my investigator that the man was very low in mood and tearful at times. He spoke about his marriage saying that he and his wife had split up on previous occasions before getting back together again. The difference this time, he said, was that he had just been sentenced to nine and a half years imprisonment and would also have additional time to serve following his escape from Forest Bank. The consensus among the review panel members was that he should be placed under constant supervision in a gated cell.
47. The psychiatrist was also at the multi-disciplinary ACCT review on 10 June. He noted his impression that the man was suffering from an acute

³ Listeners are prisoners trained by the Samaritans to provide the same service as Samaritans offer in the community.

adjustment disorder with suicidal intention (an adjustment disorder is a state of distress following a significant life change or stressful life event). The psychiatrist prescribed a different antidepressant to the one prescribed the day before. The new prescription was for Mirtazapine and was for a 28 day course of 15 milligrams per day.

48. The second RMN was on duty in healthcare and had a lengthy conversation with the man that evening. It was a routine nursing interaction unconnected with the ACCT process. The man spoke about conversations with his wife and handed her three letters that he asked her to read. Two of the letters were addressed to his wife and the other was addressed to one of his brothers. He wrote in all the letters that he had decided to take his life and explained why he had reached his decision. The second RMN asked the man if he considered the letters to be suicide letters but he said that that was not the case. Instead, he said that he had written them as a way of expressing how he was feeling. He told her that he would find it embarrassing if the letters were available for others to read. In response, she scanned the letters as “attachments” to his electronic health records. She noted the health record to say that the letters were expressions of his feelings, but she did not note the nature of the feelings he was expressing. She did not mention either the letters or the conversation in the man’s ACCT record.
49. In her interview with the clinical reviewer, the second RMN said that her conversation with the man would have been heard by the officer who was carrying out constant supervision. She also said that she briefed the unit manager. My investigator subsequently spoke by telephone to the second RMN about her handover briefing to the unit manager. She said that the handover would have taken place in the unit office and the unit manager had probably been a nurse. However, she could not recall the name of the unit manager, nor the content of their discussion.
50. The officer carrying out constant supervision that evening, 10 June, was the second Officer. She made an entry in the man’s ACCT record alluding to the contact between him and the second RMN, noting that she considered that the man’s behaviour was manipulative. In discussion with my investigator the officer explained that the man had spoken to several nurses about the problems in his marriage, asking each for their opinion about what he needed to do to re-establish the relationship. He would then recite back to her (the second Officer) what each nurse had advised. The Second Officer said that it seemed to her that the man was trying to find out which of the nurses was most prepared to engage with him in these conversations. She could not recall the man passing letters to the second RMN nor any discussion between them about any letters.
51. My investigator subsequently re-interviewed the second RMN later in the investigation, this time in person. This second interview is referred to in paragraphs 98 to 100 of this report.

52. The man had another ACCT review on 11 June. One of the panel members was the third RMN, who had also been at the review the previous day. She told my investigator that the man was much better on 11 June compared to the day before. He said that a lot had happened to him in the previous few months and he explained to the panel that his suicidal thoughts were due to the shock of all the recent events in his life. The record of the review includes his report that he felt more positive about his life and was not suicidal at that particular time. The review panel concluded that that constant supervision should cease. Instead his observations should be reduced to five per hour with four “quality interactions” (worthwhile conversations) by staff.
53. The psychiatrist was also at the ACCT review on 11 June and he examined the man after the meeting ended. He found him to be “much calmer and not so emotional”. He was thinking about his children and was no longer suicidal. At the psychiatrist’s recommendation, the man left the gated cell and was moved to a safer cell in healthcare.
54. A nurse made two lengthy entries in the man’s clinical records on the evening of 11 June covering two conversations with him. He told her that he did not feel safe in his current cell as he “could just wake in the night and take his life”. He asked to move back to the gated cell where he would have someone to talk with and someone to “save him if he did anything”. The nurse contacted the duty Governor and later that night the man was moved back to a gated cell and placed under constant supervision again.
55. The RGN chaired the ACCT reviews on 12 and 13 June. She told my investigator that, at the first of the reviews, the man showed a negative attitude towards the healthcare unit and its staff. He said that he did not feel he was getting any help but, when asked, could not explain what more he expected. The panel decided that the man should remain in the gated cell with constant supervision. She said that later that day the man asked to speak with her again when he apologised for his earlier negative attitude. He had had the chance to reflect on what had been discussed at the case review and realised that he had to work with staff.
56. In her record of the ACCT case review on 13 June, the RGN noted the man saying that he felt back to his normal self, having “lost his head for a few days”. He said that he now felt okay and was no longer thinking of suicide or self-harm. He added that his children were a reason to stop him from harming himself. The review panel agreed that he could move out of the gated cell and should be taken off constant supervision. Instead, he was to be subject to intermittent checks/observation in a safer cell.
57. The third RMN was at the ACCT review on 13 June and made an entry in the man’s clinical records saying that he had reported “feeling good and back to his normal self”.

58. The psychiatrist reviewed the man on the morning of 14 June. He man said that he felt well, was not suicidal and wanted to move out of healthcare as soon as possible. The psychiatrist noted that the man's behaviour was "spontaneous and normal" and concluded that his adjustment reaction was in full remission. The psychiatrist noted that he would review the man again the following day and consider transferring him to a standard prison wing.
59. At further ACCT case reviews on 14 and 15 June, the man reiterated that he felt much better compared to when he first arrived in Manchester. At the second review, staff concluded that his risk of harming himself was low. The level of ACCT observations was reduced and during the day staff were to observe him three times and have four quality interactions with him. At night time he was to be observed once per hour. (His next ACCT review was scheduled for 22 June.)
60. The third RMN had been at the ACCT review on 15 June after which she made the following entry in the man's clinical records:
- "...he spoke at length about his current thoughts and feelings ... says he is no longer feeling low in mood ... He was pleasant and polite, co-operating fully with the review. He said he did not have any thoughts of self-harm or suicide for the present time and said that he would approach staff if he ever experienced these thoughts again. He said he wanted to give his wife time to think and therefore would not be contacting her in the near future. He spoke about his children being positive influences in his life ... A [multi-disciplinary team] decision has been made for him to return to [E wing] ... He is happy with this decision and ... said he will speak to his friends on the wing and approach staff should he feel low in mood."
61. In the afternoon of 15 June, the man was reviewed once more by the psychiatrist further to his plan of care from the previous day. He noted that the man spoke rationally and spontaneously. His mood was stable, with no signs of mental illness or suicidal risk. The psychiatrist decided that he was fit for discharge from healthcare and so he was discharged back to E wing that afternoon. The psychiatrist also adjusted his dose of Mirtazapine, doubling the dose to 30 milligrams per day.
62. The man was appointed a personal officer when he returned to E wing. (Many prisons operate a personal officer scheme. Among other things, the personal officer is a prisoner's first port of call if they have questions, complaints or need advice.) The personal officer introduced herself to the man on 16 June. This was their first meeting but she was aware of the security unit reports that he had threatened to kill himself in telephone conversations with his family. She said that their first meeting was fairly brief as he was about to meet his lawyers. He mentioned that he had applied for some emergency telephone credit but he did not know if the money had been placed on his account. She told him that she would

check and she also took an application form with the list of his approved visitors.

63. The personal officer said that she had quite a lot of contact with the man over the following days. She described the processes for approving visitors and telephone numbers for category A prisoners as laborious and time consuming and she enquired how his applications were progressing. She said that she kept him up to date on what was happening. He accepted that they were slow processes but was anxious as he wanted people to visit.
64. My investigator met one of the man's brothers. He was also in HMP Manchester at the time but on a different wing to his brother. He is a prison Listener and he was accompanied by two members of the Samaritans.
65. The man's brother spoke in particular about the impact on his brother of being a category A prisoner. He accepted that a greater level of security checking must apply before category A prisoners can receive visitors, but questioned why his brother could not have a closed visit while the security checks were being completed. He said that his brother did not "see a friendly face" in all the time he was in Manchester. He knew that prison staff realised that his brother was at risk of harming himself and so he had asked to visit him on E wing so that they could speak together. He said that he was told that he could not do this.
66. At this point in the interview, one of the Samaritans mentioned that she also had difficulty obtaining access to prisoners held on E wing, saying that it had been many years since she had last been on that wing. She said that she too asked to visit the man to tell him that his brother was thinking about him but was refused permission.
67. My investigator asked the Safer Custody Manager, about Listener and Samaritan support for prisoners on E wing and also enquired about the man's brother's report that he had not been allowed to visit his brother. The Safer Custody Manager explained that there were several reasons why there were no trained Listeners on E wing. These included category A prisoners not wanting to be Listeners as well as other prisoners not meeting the security requirements. Also for security reasons, prisoners on E wing have not previously had access to Listeners from other wings, and have mainly been supported by using the Samaritans telephone. He said that the prison is working on a protocol to ensure that Listener support can be made available to E wing prisoners.
68. The Safer Custody Manager was previously unaware of the man's brother's claim that he had not been allowed to visit his brother. (Nor did Manchester have any record of such a request). The Safer Custody Manager told my investigator that if he had been made aware of his request, he was confident that arrangements could have been made following consultation with the security department and perhaps with the

Samaritans. (Manchester further clarified that Samaritans would be allowed onto the category A unit providing there was no operational incident taking place at the time. However, historically, it has been very unusual for category A prisoners to ask to speak with the Samaritans. Manchester believed that that would explain why the Samaritan who accompanied the man's brother had not visited E wing inner for many years. Manchester explained that a Samaritans telephone is available on the wing, but was rarely used by category A prisoners.)

69. The man was reviewed by the first RMN on the morning of 18 June. Her note of the consultation included that:

"... states that he feels better than he did this time last week and is taking one day at a time. His social stressors remain unchanged and he has not had any contact with his wife, he continues to be very distressed by the situation and is clearly still ruminating on it despite stating that he is giving his wife space. He is socialising on the unit and fellow prisoners, and discipline staff report he appears more positive within mood. He did question his prescribed antidepressant stating that he feels they are not allowing him to think clearly and wants to stop taking them, advised him to continue [taking] the antidepressant and will arrange [an appointment with the psychiatrist] ... at present denies any thoughts of self harm or suicide."

70. Later that morning, the personal officer made a note saying:

"... has been in a much better frame of mind since coming back onto the unit a few days ago and has been out on association talking to other prisoners as well as chatting to staff. He has also made steps towards getting his family approved to visit. States he feels more optimistic and settled."

71. The first SO chaired the next ACCT case review on 22 June. He told my investigator that the man seemed brighter and more focussed that day and he asked for the ACCT plan to be closed. The review panel judged his level of risk to be low, but they did not consider that the ACCT support should be brought to an end. No change was made to the level of interactions and observations, which meant that he continued to be observed three times in the day with four quality interactions. At night time he was to be observed once per hour. (As a category A prisoner, he was in any case subject to hourly checks through the night.) The next case review was scheduled for 5 July.

72. The first RMN was at the case review on 22 June. She made an entry in the man's clinical records to say that he had described himself as feeling more settled in the prison and his mood was much better. He also reported that he had stopped taking his antidepressant medication despite her advice that he should continue with it. His records show that he had refused the medication from 19 June onwards. He explained to her that

the medication gave him bad dreams so he was better off without it. She noted that she would discuss the matter with the psychiatrist.

73. The personal officer was also at the ACCT case review on 22 June and she too mentioned in discussion with my investigator that the man reported feeling much better and asking for the ACCT plan to be closed.
74. The fourth staff representative at the ACCT case review that day was a prison chaplain. The chaplain noted that the man was anxious to start receiving visits from his family. She attempted to telephone the man's mother, but without success, so then telephoned one of his brothers. He told her that the family were "all fine" and were attempting to arrange a closed visit to the man. She passed this message to him.
75. The third Officer told my investigator that he was the cleaning officer on E wing. (The cleaning officer supervises the prisoners who clean the wing and who serve the meals.) He explained that his role meant that he was always out on the landing so he had frequent contact with most prisoners. He had a number of dealings with the man relating to clearance of telephone numbers and visitors. He described the man as quiet compared to other prisoners who had been on the wing for several months, but he did not seem obviously upset at any time.
76. The third officer made an entry in the man's ACCT record at just after 10.30pm on 22 June following a "short chat". He noted that the man said he would be staying on the ACCT plan for another week or so. He accepted this even though he said he was ready for the plan to be closed. The third officer concluded his note by noting that the man seemed in a "bright mood".

23 June

77. The personal officer made two entries in the man's ACCT plan on 23 June. In the first entry, made at 10.10am, she noted that he had received his canteen⁴, spoken by telephone to his family and looked more "upbeat". In her second entry, made at 11.00am, she noted that the man had received notification of his prison release date and was very optimistic saying that the time would go quickly. (His earliest release date, dependant on parole, was calculated to be 7 June 2014, although he was liable to have time added because of his escape from HMP Forest Bank.) The personal officer told my investigator that the man had seemed to improve in mood over the week or so that she knew him. They had chatted about various things, including their respective children. He had also begun to spend more time out of his cell on association, having made some friends on the wing.

⁴ The word canteen refers to the prison shop. Prisoners are able to spend their own money on items such as tobacco, toiletries and sweets. They submit their orders by completing canteen sheets.

78. Other entries in the man's ACCT plan made on 23 June might also suggest that he was in good spirits that day. He asked for extra chips when he collected his midday meal and he also collected extra food with his evening meal.
79. The man made a great number of telephone calls to various family members on 23 June. A number of his calls were unanswered, while in others he spoke to different family members about completing relevant paperwork so that they could visit. He made two calls asking for his property to be brought to the prison. In other calls to family members, he spoke about concern over what he understood to be on his wife's 'Facebook' page. He made ten calls to his wife but none were answered and generally he left no message. He left messages on three occasions, telling his wife that he loved her and was upset about what he understood was on 'Facebook'.
80. The third Officer was on duty on the night of 23 June. At 8.30pm he made an entry in the man's records that he was sitting on his bed watching football on television. The third Officer asked the man how he was and he replied that he was okay. Around an hour later the third Officer went to check him again. When he looked into the cell the man was not in the main cell area and so the third Officer concluded that he must be in the toilet. The third Officer tapped the cell door but the man did not respond. The third Officer was not unduly concerned at that stage as a lot of prisoners would be using the toilet/wash room at that time in the evening. As all high-risk category A prisoners and e-list prisoners must be checked hourly through the night, the third Officer first checked on other such prisoners on the wing before returning to the cell a few minutes later. There was still no sign of the man in the main cell area and so the third Officer tapped the cell door again and then kicked it. There was still no response and third Officer went to the wing office to get help. There was no one in the wing office and so he radioed for assistance.
81. Another of Manchester's senior officer told my investigator that he worked in Manchester's security unit and that evening was working as the duty Assistant Night Orderly Officer (NOO)⁵. He confirmed that officers working on the wings at night carry cell keys, which are contained in a sealed pouch. The pouch should only be broken and a cell entered in the case of an emergency. As the Assistant NOO, he carried open keys, but restrictions still apply to unlocking cells at night time which usually include the attendance of a dog and handler. That particular requirement can be overridden by the overall officer in charge, the NOO.
82. The Assistant NOO said that as the man was not in his cell it was assumed that he was in the toilet. The NOO had a key to open a separate door leading to a service duct which allows restricted sight of the toilet area via two Perspex windows spaced several feet apart. Looking into the

⁵ The Night Orderly Officer (NOO) is the person in operational charge of a prison at night time and the Assistant NOO is second in charge.

toilet area, he thought that he could see a line (a ligature) running down from the window bars. He shouted to his colleagues that he believed the man was hanging. (My investigator went into the service duct and confirmed for himself that visibility into the toilet area was poor.)

83. The NOO unlocked the cell door and staff went into the cell. When they went into the toilet area they saw the man hanging from a ligature which was tied to the window frame. One officer took hold of the man to relieve the pressure from the ligature and another officer used his anti-ligature knife to cut the ligature. The officers lowered the man to the ground, removed the remnants of the ligature from his neck and tried to find a pulse. A radio call was made for healthcare assistance (this was timed at around 9.50pm) and the third Officer went to the wing office to collect first-aid equipment. By the time he had returned to the cell with the equipment, nursing staff had already arrived.
84. The emergency response nurse told my investigator that she was in the healthcare unit when she heard the emergency call. She and another nurse went to E wing, taking an emergency bag and a defibrillator⁶. The emergency response nurse wrote in a statement that she examined the man and found that his pupils were “fixed and dilated”; he had no pulse and no signs of breathing. He was checked with the defibrillator which advised that shock should not be given and cardio pulmonary resuscitation (CPR) should commence. She said that she started to give chest compressions while her colleague gave oxygen. They periodically rechecked the man with the defibrillator but it repeated each time that no shock be given and that CPR should continue.
85. An emergency ambulance was requested at the same time that healthcare assistance was called for. The ambulance arrived at the prison at just before 10.00pm and the crew, who were both ambulance technicians, reached the cell five minutes later at 10.05pm. The emergency response nurse said that the ambulance crew helped with the efforts to administer CPR. The man was taken to the ambulance in a wheelchair while CPR continued along the way. Ambulance technicians are not able to formally pronounce death, but it seems that they telephoned for more senior clinical advice and, at 11.15pm, the man was deemed to have died. The ambulance was still at the prison at this time. It eventually left the prison at 1.15am.
86. One of Manchester’s Roman Catholic chaplains told my investigator that he was also one of the prison’s family liaison officers. The man was a Roman Catholic and the chaplain said that he met him four or five times during his time in Manchester. The man told the chaplain that his sister’s death, and his recapture following his escape from Forest Bank, had both affected him quite badly. The chaplain said that he had had a number of telephone conversations with the man’s mother and aunt during the same

⁶ A defibrillator measures for presence of electrical activity in the heart and emits audible instructions on management of the patient.

time, and both were worried that the man might take his life. The chaplain tried to make the man understand the impact on his family if he were to commit suicide. The chaplain thought that the man had begun to settle and he was hoping to get some photographs of his children. The chaplain said that he was telephoned at home on the evening of 23 June to be told that the man had hanged himself. He went into the prison and blessed the body.

87. The chaplain and one of Manchester's Safer Custody Officers were asked to visit the man's family to break the news. The address they were given turned out to be the home of his mother-in-law. From there they went on to his home where they broke the news to the man wife.
88. The Safer Custody Officer said that after the man's wife had been told about her husband's death, his concern began to focus on the man's brother. The Safer Custody Officer did not want the brother to find out what had happened through hearing other prisoners shouting from their cell windows. He and the chaplain therefore agreed that he would return to the prison while the chaplain would visit the man's mother. The Safer Custody Officer said that when he got back to Manchester he woke the man's brother to tell him.
89. The chaplain told my investigator that, having broken the news to the man's wife, he went on to the man's mother's home while the Safer Custody Officer returned to the prison. The chaplain told the mother of her son's death and remained in the house for about three hours. In due course the man's father and one of his brothers arrived and later his grandparents came too. The chaplain said that when breaking the news of a death he will try to judge whether the family would prefer him to leave the home fairly soon or whether they prefer him to remain a little longer. With the family, he judged that they would prefer that he stayed and he led them in prayer.
90. A hot debrief meeting with staff was conducted by the duty Governor and the care team were made available to them. Support was also offered to other prisoners and in particular to the man's brother.
91. Members of the family later came to the prison and met the Governor. The man's father and one of his brothers visited his cell. After that, the chaplain took the family to the chapel where they lit candles. The family were offered assistance with the funeral expenses.
92. All prison wings have post boxes into which prisoners post their letters. When the E wing post box was emptied on the morning of 24 June, it contained a letter written by the man. The letter was dated 23 June and was timed 8.30pm (around the time prisoners would be locked in their cell for the night on E wing). The letter was written to an acquaintance of the man's. It was optimistic in tone and asked the recipient to write back.

ISSUES

Manchester's Category A unit

93. HMP Manchester's primary purpose is as a local prison serving the courts in the Greater Manchester area. In addition, it functions as a high security prison holding 53 category A and e-list prisoners who are held on E wing inner. E wing inner is a self-contained unit which has a separate and more restricted regime compared to the rest of the prison.
94. There were several implications for the man through being both a category A prisoner and e-list prisoner. One of these was that, even by the time of his death 26 days after he was taken to HMP Manchester, he had yet to receive a family visit. Although his list of telephone contacts had been cleared within a few days of his arrival into Manchester, the people on his visiting list were still being security vetted (as I have explained, a higher level of vetting is required for visitors to category A and e-list prisoners). Had the man submitted an application to receive closed visits from members of his immediate family, this could have been granted at the Governor's discretion. Information about visiting arrangements, including the facility to request closed visits, is contained in a booklet issued to prisoners during the prison induction process. In addition, from a discussion between a member of the chaplaincy team and one of the man's brothers, it also seems the family might well have been aware of the facility.
95. Another implication for the man from being a category A and e-list prisoner was that his brother, who was based on another wing, was apparently told that he could not visit him. The brother apparently asked if he could do so as he was aware that the man was potentially at risk of harming himself. I understand from the evidence given by the Safer Custody Manager that arrangements could have been made, even though that would have involved input from the security department. It is disappointing that, despite two periods under ACCT monitoring, no consideration was given to arranging for the brothers to meet.
96. My investigator also asked the Safer Custody Manager about access to Listeners for category A and e-list prisoners. The provision of Listeners is widespread throughout the prison estate and they provide valuable support to prisoners who are at risk of harming themselves. I am concerned that there are nevertheless no trained Listeners on E wing. I understand that this is mainly because of the security implications surrounding category A prisoners. I am pleased to learn from the Safer Custody Manager that the prison is developing a protocol by which Listeners based on other wings can be safely brought to E wing when they are needed.

97. The clinical reviewer also considers that the man would have benefited from having access to a Listener. (Manchester has commented that the man had previously worked as a Listener so was aware of the scheme. However, he did not ask to speak with a Listener. Manchester also commented that the man was informed that the Samaritans telephone was available.)

I recommend that, if not yet in place, the Governor should ensure that Listener support is made available to E wing prisoners without further delay.

The letters given to the second RMN

98. On 10 June, the man gave three letters to the second RMN in the course of a routine nursing contact. Two letters were addressed to his wife and one to a brother. In all, the man wrote about his intention to take his life and the reasons behind his decision. When the second RMN asked him if they were suicide letters he denied that to be the case, saying that he had written them as a way of expressing his feelings. He added that he would find it embarrassing if the letters were to be seen by a wider audience and so he asked for them to be kept out of his ACCT plan. The second RMN agreed to his request. She said that she briefed the wing manager, but she could not recall who this was that evening. She made no entry in the man's ACCT plan about the letters or of their conversation. In his clinical record, the second RMN noted that the man had handed her some letters which he explained were written to express his feelings, but she included only that stark detail.
99. Staff will often need to consider carefully how they should deal with matters that prisoners divulge in confidence. If the prisoner's request for confidentiality is not honoured, it might deter them from ever again disclosing potentially important information. However, staff also have a duty to keep prisoners safe especially those, such as the man, who are being supported by ACCT monitoring. I consider that it would have been possible for the second RMN to have noted in the ACCT form, and in the man's clinical records, the essence of what he had written in his letters together with his explanation that this was not a real suicide plan but merely capturing his thoughts. Of course she would have needed to explain to the man what she intended to do.
100. As indicated earlier on in this report, an advance draft was disclosed to the services in remit due to the criticism made of the actions of the second RMN. During a second interview with my investigator, the second RMN reiterated what she had said previously about the man wanting his letters to remain private and that he confirmed to her that the letters were not statements of intent to self-harm, but were instead an expression of his thoughts. While I recognise the potential dilemma for her, I remain firmly of the view that she should have made an entry in his ACCT form to reflect the substance of their conversation.

I recommend that the Governor and Head of Healthcare remind all staff about the importance of recording significant conversations and events in ACCT plans and in the clinical records.

Frequency of ACCT conversations and observations

101. Prison Service Order (PSO) 2700 deals with suicide and self-harm prevention and it includes guidance on the ACCT process. This includes some guidance on the setting of conversations and observations. PSO 2700 gives no examples however of situations where any particular level of interaction might be applicable. Nor is such guidance contained in the ACCT training that all staff undertake. Guidance is not given because staff are expected to deal with prisoners as individuals and tailor the support plan to the individual and their prevailing circumstances.
102. Deciding on what would appear to be an appropriate level of interaction in the man's case was therefore a matter for the judgement of the review panels who sat to consider his needs over the period of time he was subject to ACCT monitoring and support. I note in passing that the reviews were held as often as they were required and that an additional review was called at short notice on one occasion. I am also pleased to see that each review was attended by various multi disciplinary staff and that the man was present on every occasion.
103. The final ACCT case review was held on 22 June, the day before the man's death. Based upon the written record of the review and the oral evidence of the staff to whom my investigator spoke, the man's mood seemed to have lifted. He said that he was feeling much better and asked for the ACCT plan to be closed. The panel members accepted that the man's mood had lifted but they told him they would keep the ACCT plan open for the time being. By that time, the level of interactions with him was three observations and four quality interactions during the day. At night time he was to be observed once per hour. (As a high-risk category A prisoner and e-list prisoner, he was in any case subject to hourly observations at night.)
104. Having mentioned all of the above, I consider, on balance, that the man could have been subject to more frequent observations, certainly at night time. He had said previously that the most difficult time was when he was locked in his cell and alone with his thoughts. In addition, it is clear that he was still trying to come to terms with all that had happened to him in the previous few weeks. This included his marital difficulties and he was also still waiting for clearance for family members to start visiting him. If he been subject to night time observations at a greater frequency than one per hour, that would have clearly separated him from the other prisoners on E wing in the minds of the staff. He might also have found this additional support reassuring. While I make no criticism of the decision making of the review panel, the Governor will no doubt wish to reflect upon any lessons that can be learned from the man's specific circumstances.

The delay before staff went into the man's cell on 23 June

105. When the third Officer checked the man at 8.30pm, he was sitting on his bed watching football. At the time of the next check an hour later, the third Officer assumed that the man was using the wash basin/toilet as he was not in the main cell area. He did not respond to taps on the door and the third Officer decided to leave him while he checked the rest of the wing. When the third Officer returned, the man could still not be seen. This time the NOO was called, leading on to the discovery that the man was hanging. It seems likely that around ten minutes might have elapsed from the time of the third Officer's first check to the point that staff cut the ligature.
106. As already discussed, the man was subject to hourly ACCT checks through the night. He would in any case have been subject to hourly checks through the night as a security measure given that he was a category A prisoner. I think that it rather defeats the purpose of these checks if officers neither observe nor obtain a response from the prisoner at the exact time of the check. I consider that the third Officer should have persisted in attempting to obtain a response from the man when he made the check at 9.30pm and should have called for assistance without delay once it was obvious that he was not responding.

I recommend that the Governor should consider revising the instructions to staff when conducting night-time checks on category A prisoners. If the prisoner cannot be seen, the officer should request a verbal response before moving on.

Confirming that the man had died

107. The clinical reviewer found that healthcare staff made appropriate efforts to try to resuscitate the man. However, my investigator also spoke with the Legal Services Co-ordinator from the Ambulance Trust to ask about the status of an ambulance technician. The Co-ordinator explained that ambulance technicians are able to carry out most of the procedures carried out by paramedics, but they cannot intubate or cannulate patients (intubation and cannulation are the insertion of tubes and lines into the body). The Co-ordinator said that the ambulance trust does not employ a sufficient number of paramedics to ensure that all emergency response vehicles are staffed by such professionals. When technicians require greater expertise, then paramedics are called for. She added that the evidence was that the man's care was not compromised either through the presence of ambulance technicians or the time it took before the ambulance left the prison.

The delay before the ambulance departed

108. The man had a previous history from long before of absconding from prisons. He also had a much more recent history of a violent escape from a closed prison. He was in HMP Forest Bank when he deliberately cut his

ear. An ambulance was called to the prison to transfer him to outside hospital. While on the way to hospital the ambulance was intercepted by an armed gang, affecting his escape. He remained at liberty for three weeks before being re-arrested at the end of May 2010. As a result he was classed as a category A (high risk) prisoner and an e-list prisoner. For all such prisoners, greater levels of security arrangement are put in place. Such arrangements include a requirement upon the accommodating prison to obtain formal sanction from Prison Service headquarters before transferring the prisoner to hospital. In his case this took some time to achieve.

109. Having sought more senior clinical advice, the ambulance technicians deemed at 11.15pm that the man was dead. In reality it would seem his death actually occurred much earlier in which case his care would not have been compromised through the delay in the departure of the ambulance. My investigator spoke with the deputy Governor about this matter. The deputy Governor said that the departure of the emergency vehicle would not have been delayed had there been any prospect that the man's life could have been saved.
110. My investigator spoke with Manchester's deputy Governor about the delay before the departure of the ambulance on the night of the man's death. He said that ordinarily authorisation from Prison Service headquarters must be obtained when transferring a prisoner such as the man, who was a category A prisoner and also an e-list prisoner with a history of violent escape. In addition, the ambulance crew were reluctant to take him without an escort given his previous violent escape from an ambulance. It therefore took time to obtain authorisation for the transfer. He assured the investigator that, had there been any prospect of saving the man's life by taking him to hospital, the ambulance would have been allowed to leave immediately whilst the necessary authorisation and security issues were actively underway. I accept his assurance on this matter.

Matters following the man's death

111. Manchester's Roman Catholic chaplain, with the role of prison family liaison officer, was at home on the evening of 23 June when he was contacted by the prison and told of the man's death. The chaplain went into the prison and blessed the body. After that the chaplain, in company with the Safer Custody Officer, visited the man's family to break the news. (The chaplain had previously spoken by telephone with the man's mother and aunt whilst was alive.) Both were conscious of the danger that the man's brother might hear the news of the man's death from other prisoners and so the Safer Custody Officer returned to the prison to speak to him. The chaplain then remained with the family for the next several hours during which time he led them in prayer. I consider that the chaplain and Safer Custody Officer demonstrated the very best of practice in carrying out this important and sensitive role.

Findings from the clinical reviewer

112. The clinical reviewer found that the psychiatrist's diagnosis that the man was suffering an adjustment disorder was appropriate. However, the reviewer considered that it was too early for the psychiatrist to conclude on 14 June that the condition was then in full remission. The reviewer also found that the psychiatrist did not appear to take a systematic or thorough exploration of symptoms that might have been indicative of depression.
113. The clinical reviewer considered that prescribing anti-depressants was reasonable, especially as the prescription was not made in isolation from other approaches. The reviewer did not believe that the man's mental health deteriorated when he stopped taking his anti-depressants.
114. The clinical reviewer identified a number of omissions in the completion of the man's prescription charts, other healthcare documents and ACCT plans. He also identified omissions in the process for checking of emergency healthcare equipment.
115. At interview with nursing staff, the clinical reviewer identified inconsistencies in the support offered to staff following the man's death. Both of the nurses involved in the attempts to resuscitate the man attended the hot debrief on the morning after his death but neither attended the subsequent cold debrief. One was absent because she was on holiday at the time but the other was not invited. A third nurse who had significant involvement with the man was not invited to the cold debrief, nor offered support from the care team. In addition, she was dissatisfied with the way in which she was informed of the man's death.
116. The clinical review makes 10 recommendations, which I summarise below. These were directed to the Governor and Head of Healthcare and responses following consideration at draft stage are contained in italics below each recommendation.

The Head of Healthcare should, in consultation with the GP service, ensure that locum doctors are adequately inducted into their role at Manchester, particularly with regard to the ACCT process.

Response: Recommendation accepted. The ACCT procedures are written into the GP Locum pack provided to the member of staff. Due to the transient nature of locum doctor provision, many of whom attend the prison for just one day, it would not be feasible to give all the locums full ACCT induction. To ensure the risk is managed all locum GPs are escorted by an ACCT trained healthcare member of staff for guidance and support.

The Head of Healthcare should explore with the in-patient and mental health in-reach teams, potential problems in the way the teams work together and the extent to which this influences clinical practice.

Response: Recommendation accepted. Systems are now in place to ensure admission and discharge procedures and assessments are jointly managed.

The Head of Healthcare should ensure that appropriate clinical supervision is provided for healthcare staff at Manchester.

Response: Recommendation accepted. On a monthly basis healthcare staff have the opportunity to book in for individual clinical supervision sessions. An e-mail has been sent to all staff reminding them of the benefits of attending clinical supervision. Target for completion: 31 December 2011.

Training should be organised for mental health in-reach team staff in the completion of the standard assessment form in use by their team.

Response: Recommendation accepted. Training will be given by the Manchester Mental Health and Social Care Trust. Target for completion: 31 December 2011.

The Head of Healthcare should ensure that the allergies/sensitivities section of prescription charts is completed. Compliance should be monitored as part of a regular audit.

Response: Recommendation accepted. This will be implemented. It is also incorporated into the electronic system. Target for completion: 31 December 2011.

There should be regular audit of the quality of clinical record keeping, ensuring that standards reflect the guidance of the relevant professional bodies. Healthcare staff taking part in the ACCT process should record significant developments in the corresponding clinical record.

Response: Recommendation accepted. Clinical record keeping forms part of the annual audit calendar. Guidance will be published on cross referencing between the ACCT documentation and the corresponding clinical record. Target for completion: 31 December 2011.

The Head of Healthcare should ensure that the quality of record-keeping by healthcare staff in ACCT plans is audited regularly.

Response: Recommendation accepted. The ACCT process is not a clinical intervention and as such all ACCT documents are regularly checked by prison managers to ensure they are of high quality. This provides assurances that ACCT entries are of a good standard and reflect appropriate management of the identified issues. This practice applies to all areas of the establishment including Healthcare.

The Head of Healthcare should review and monitor the process for obtaining previous prison or community records for prisoners arriving at Manchester.

Response: Recommendation accepted. All records where an identified GP is known are requested as a matter of standard practice. All prisons are now on System One so any prisoners received in to Manchester from other establishments are requested and sent electronically. Target for completion: 31 December 2011.

The Head of Healthcare should liaise with the Ambulance Trust to determine the need for any particular arrangements on the expertise of ambulance personnel called when a prisoner is found hanging at Manchester.

Response: Recommendation accepted. A policy is now in place with the Ambulance Service.

The reliability of the system for identifying and approaching staff affected by serious incidents should be reviewed.

Response: Recommendation accepted. The process by which staff are identified and supported post incident will be reviewed. Target for completion: 31 December 2011.

CONCLUSION

117. The man had been in Manchester for a little under a month when he took his life. He experienced many stressful events around and just before this time. They included the suicide of his sister, being found guilty on charges of conspiracy to convert criminal property following a lengthy trial, his escape from prison and recapture and being sentenced to nine and a half years imprisonment with a likely additional sentence for his escape from prison.
118. However, by all accounts, the most significant single factor for the man was the difficulty in his marriage. He spoke about these difficulties at ACCT reviews and in consultations with nurses. Staff advised him to give his wife time and to try to take each day of his sentence at a time. In principle he appeared to accept that he needed to do so. However, despite his apparent acceptance, it is clear that he found it difficult to put the advice into practice. As a result there were times when his mood swung quite markedly in a brief period.
119. By 23 June, the man was undoubtedly more settled than he had previously been. However, he was still being supported through the ACCT process, even though he was by then on a low level of observations and interactions. It remains very unclear from this investigation whether he truly intended to take his life when he did. He had written several apparent suicide letters to family members several weeks before his death, but voluntarily handed them to a nurse. In discussion with the nurse he denied that they were suicide letters, he said, instead, that he found it helpful to have expressed some of his thoughts on paper.
120. On the day of his death, less than one hour appears to have elapsed between the man posting a letter to an acquaintance inviting a response and then him being found hanging in his cell. This investigation has found that he was having considerable difficulty accepting the recent events that had happened to him. While I make no criticism of the actions of staff, I do consider that lessons could be learned in respect of the support available to at risk Category A prisoners at Manchester.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. I recommend that if not yet in place, the Governor should ensure that Listener support is made available to E wing prisoners without further delay.

Prison Service response: Recommendation accepted. A protocol is currently being developed to provide listener support to the Category A Unit. Target for completion: 31 December 2011.

2. I recommend that the Governor and Head of Healthcare remind all staff about the importance of recording significant conversations and events in ACCT plans and in the clinical records.

Prison Service response: Recommendation accepted. Guidance will be sent to staff regarding the recording of significant conversations and events in ACCT plans and in the clinical records. Target for completion: 31 December 2011.

3. I recommend that the Governor should consider revising the instructions to staff when conducting night-time checks on category A prisoners. If the prisoner is in the toilet, the officer should request an oral response before moving on.

Prison Service response: Recommendation accepted. The instructions to night staff on the category A Unit will be reviewed. Target for completion: 31 December 2011.

COMMENDATIONS

1. I commend the family liaison team, the chaplain and Safer Custody Officer, for the thoughtful and sensitive way in which they dealt with the man's family following his death.

Prison Service response: Formal recognition will be given to the officer and chaplain for this family liaison work.