

**Investigation into the circumstances surrounding the  
death of a man, a prisoner at HMP Risley  
in November 2010**

**Report by the Prisons and Probation Ombudsman  
for England and Wales  
November 2011**

This is the report of the investigation into the death of a man, a prisoner at HMP Risley, who died in November 2010 having been found hanging in a cell in the Care and Separation Unit. He was 43 years old at the time of his death.

I extend my condolences to his family and those that knew him. I trust this report goes some way to answering any questions they may have. I apologise for the delay in issuing this report.

The investigation into the death was undertaken by one of my investigators. In addition to my own investigation, a clinical reviewer was commissioned by the local Primary Care Trust (PCT) to undertake a clinical review of the man's care whilst in custody. I am grateful to him for his review and I commend it to both the Governor and Head of Healthcare at Risley.

I would also like to thank the Governor of Risley and his staff for their help and assistance with this investigation. I also thank the liaison officer, the Regimes and Resources Manager, for his assistance to my investigator during the investigation.

The National Safer Custody and Learning Team also conducted a review of safer custody at Risley, with a specific focus on the care and management of the man whilst he was segregated in the Care and Separation Unit. Their review identified lessons learned to inform national policy and, in particular, the implications for the policy on segregation.

He died of self inflicted injuries. He had been moved to the Care and Separation Unit the day before he died because of concerns about his behaviour. While he was at Risley he received a considerable amount of support from healthcare and mental health in-reach team, as well as from discipline staff. My report examines the support he received, the decision making process which led to him being moved to the Care and Separation Unit, and the emergency response.

I make six recommendations to the Governor at Risley. These relate to providing clear, accurate and up to date information on sentence progression and parole dates, management of out of hours mental health emergencies, bereavement counselling services, use of Care and Separation Unit and first aid and life support training. The prison service has accepted five and accepted in principle one of the six recommendations and their comments on these can be found at page 33 in this 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**

**November 2011**

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## SUMMARY

1. The man was arrested by police on 4 July 2005 on suspicion of the murder of his partner and threats to kill his son. A psychiatric examination of him while he was in police custody found him to be psychotic, and he was sectioned under the Mental Health Act to a Clinic in Merseyside, under the care of a consultant forensic psychiatrist. Whilst at the Clinic, he was admitted to hospital and was diagnosed as suffering from severe liver disease. The consultant diagnosed his psychosis as probably caused by hepatic encephalopathy (arising from the liver disease) and psychological factors. His antipsychotic medication was discontinued and he was managed without relapse into psychosis.
2. He was subsequently remanded into prison custody at HMP Liverpool on 23 May 2006. In August 2006, following trial at Crown Court, he was convicted of manslaughter on grounds of diminished responsibility and threats to kill. Sentencing was adjourned.
3. Before he was sentenced, he set fire to himself and his cell, saying he wanted to die. An ACCT was opened (ACCT, Assessment, Care in Custody and Teamwork, which offers care and support to prisoners at risk of suicide or self harm) and he was again prescribed antipsychotic medication until his mental state improved. Stress was identified as a psychological factor. In October, another ACCT was opened for a short period.
4. On 21 November 2006, he was sentenced. He remained at Liverpool and, after a further ACCT was opened, he began to make progress. In February 2009, his first parole application was rejected and he was required to attend further offending behaviour programmes.
5. He was transferred to HMP Risley on 20 March 2009. His physical condition improved and, although he received a fractured jaw after being assaulted, he achieved enhanced privilege status and completed offender programmes. His next parole review was scheduled for October but was delayed. He began to show signs of stress and have paranoid ideas. At the end of October, another ACCT was opened.
6. On 22 November, following serious uncharacteristic and paranoid behaviour (kicking and punching his cell door, threatening to kill other prisoners and hearing voices) in his cell, he was moved in the Care and Separation Unit for his own interest because of his deteriorating mental health. He denied that he was planning to harm himself, and was due to be assessed by a psychiatrist.
7. The following morning, on 23 November at 5.30am, an officer found him hanging in his cell. Despite a swift emergency response, his death was pronounced by paramedics at 5.55am.
8. I make six recommendations to the Governor at Risley. These relate to providing clear, accurate and up to date information on sentence progression and parole dates, management of out of hours mental health emergencies, bereavement counselling services, use of the Care and Separation Unit and

first aid and life support training. The Prison Service has accepted five and accepted in principle one of the six recommendations and their comments on these can be found at page 33 in this report.

## THE INVESTIGATION PROCESS

9. One of the Ombudsman's investigators was appointed to conduct the investigation into the man's death. He opened the investigation on 29 November 2010, speaking with a number of staff at the prison, including the Head of Regimes and Resources, who also acted as the prison's liaison officer for this investigation. The investigator's contact details were made available to members of the Independent Monitoring Board (IMB) and the Prison Officer's Association.
10. The Ombudsman's terms of reference, and notices to staff and prisoners, were sent to the Governor at the beginning of the investigation. I understand that they were displayed around the prison inviting prisoners or staff to contact the investigator should they wish to. At the time of publication of the draft report, there had been no response to the notices. During the investigation, the investigator provided verbal and written feedback to the Governor of Risley.
11. A review of the man's healthcare was commissioned from the local PCT. The review was undertaken by the clinical reviewer who attended Risley and interviewed a number of healthcare staff.
12. The investigator reviewed the man's medical records and other prison documentation. He also interviewed a number of staff at the prison, and liaised with the clinical reviewer.
13. One of the Ombudsman's family liaison officers contacted and visited the man's mother and sister, informing them of my investigation into his death. The family raised the following areas of concern:
  - The level of medical care he received given that he had been diagnosed with a history of mental health problems
  - What mental health risk assessments were in place at HMP Risley
  - Whether he was on any medication
  - Why was the decision made move him to the Care and Separation unit?

I hope that my report explains the circumstances around his death and answers these and any other questions the family may have.

## **HMP RISLEY**

14. HMP Risley is a modern, purpose built prison that opened in 1964. It is a category C training prison. Since the opening of a new wing in 2003, it has a capacity of 1,085, making it the largest category C prison in the country.
15. Healthcare staff are available in Risley 24 hours a day. By day, there is a doctor in the prison; at night, cover is provided by nursing staff. There is no in-patient facility at Risley. Prisoners who require in-patient treatment are referred to other prisons or to outside hospital.
16. Healthcare services at Risley are commissioned by the National Health Service (NHS), through the local Primary Care NHS Trust. A mental health in-reach team is provided by the local Mental Health Trust.
17. Since the Ombudsman started investigating deaths in custody in April 2004, there have been nine deaths at the prison, up to and including that of the man. None of the circumstances of these deaths were similar to his.

## **Her Majesty's Chief Inspector of Prisons (HMCIP)**

18. The most recent HMCIP inspection was unannounced and took place in April 2008. There are a number of recommendations in the Chief Inspector's report relevant to the circumstances of the man's death. These are:
  - Systems should be in place for the management of out of hours mental health emergencies."
  - Mental health day care provision should be provided for those less able to cope with life on the wings.
  - Safety algorithms should be fully completed by healthcare staff.

## **Independent Monitoring Board (IMB)**

19. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The most recent 2009-10 annual report by the IMB for Risley contains an issue which needs to be reflected upon here. Specifically:

"As in previous years it is the opinion of the Board that the prison system will not operate effectively until facilities are created to house and treat prisoners with serious mental health problems".

The Board had found in the previous year that a prisoner with mental health issues had been placed in what it regarded as unsuitable accommodation, namely a gated cell under constant watch. It did find, however, that transfers to the in-patient facility at HMP Preston had been resolved more quickly for those with urgent needs.

## **Care and Separation Unit (CSU)**

20. The purpose of the Care and Separation Unit is to maintain safety, order and discipline and respect for human dignity. Segregation can be necessary to help prisoners address negative aspects of their behaviour and return to normal location as soon as possible.
21. A prisoner may be segregated for many reasons. Examples include a prisoner who has been found guilty of breaking discipline rules or if their behaviour is so disruptive that keeping them in their normal location may be unsafe. A prisoner can also be held in the Care and Separation Unit for their own safety if they are threatened by other prisoners. This should only be considered as a last resort when a specialist or vulnerable unit is not available. The Care and Separation Unit does not have televisions or radios. Healthcare staff visit the Care and Separation Unit daily, nurses give out medications and the doctor visits three times per week. A governor and a member of the IMB will also visit the unit daily to check upon prisoners well being.

## **Critical Incident Debrief and 'Hot Debrief'**

22. A critical debrief takes place normally two weeks after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, identify any learning points, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment. A 'hot debrief' takes place immediately after a serious incident allowing staff to receive immediate support and identify anything that needs to be rectified immediately to prevent further deaths or injury.

## **Cut down tools**

23. Anti ligature knives (commonly referred to as fish knives because of their fish like shape) are cutting tools designed for safely cutting ligatures and are carried by all officers and healthcare staff in contact with prisoners.

## **Emergency response codes**

24. Emergency codes are used to summon staff to deal with a particular situation. At Risley, a Code Black is used to indicate a life threatening incident or a prisoner is unconscious.

## **Listeners**

25. Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners. They do not offer counselling but offer support, particularly for prisoners at risk of self harm.

## **Reception and induction**

26. A Cell Sharing Risk Assessment (CSRA) is opened by a reception officer who completes the basic details. The CSRA is intended to provide consistent and continuing risk assessment about the prisoner's potential to harm a cellmate. While this is primarily for sharing with other prisoners, it also includes occasions when space may be shared, for example to accommodate a Listener.
27. The initial healthcare screen concentrates on the prisoner's immediate well-being. The healthscreen includes questions about the prisoner's mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.
28. All new prisoners are located on the induction wing. Prisoners are asked about any immediate concerns, such as disability, their offence and general well being. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, and telephone pin numbers and visiting arrangements are explained.

## **Suicide and self harm monitoring**

29. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify prisoners' individual needs, and provide individualised care and support before, during and after a period of crisis.

## KEY FINDINGS

### Prior to the man's arrival at HMP Risley

30. The man was born in June 1967. He lived with his partner of nine years, her two teenage daughters and his young son. He was employed as a scaffolder. He had started to use heroin in his late teens, and had committed several acquisitive crimes to help him fund his drug use. He had received community penalties for these crimes, although he also spent some time in a youth custody facility.
31. After being arrested by the police on 4 July 2005 under suspicion of murder and threats to kill, he was examined at the police station the following day by a forensic psychiatrist. He was found to be psychotic and was sectioned under the Mental Health Act and detained for assessment at a clinic, a medium secure unit in Merseyside, under the care of a Consultant Forensic Psychiatrist.
32. Whilst at the clinic he was admitted to hospital on a number of occasions, and he was diagnosed with severe liver failure (cirrhosis) and related conditions of oesophageal varices (a severe throat disease) and blood deficiency. The psychiatrist initially treated him with antipsychotic medication (risperidone) but, following diagnosis of his physical conditions, she assessed that his psychosis was most likely to be related to hepatic encephalopathy (altered states of consciousness, sometimes psychotic, resulting from liver failure) and psychological factors. She diagnosed that he was not suffering from a formal mental illness. His antipsychotic medication was stopped and physical conditions were stabilised. Subsequently, he was managed at the clinic without any psychotic relapse.
33. On 17 May 2006, the psychiatrist wrote to the medical officer at HMP Liverpool advising of his diagnoses and treatment, as part of a planned transfer into prison custody. She indicated that at times of low mood he had reported having thoughts of self harm but without any plans. Noting that his main motivation for carrying on was his son, she indicated that the risk of him harming himself might rise during his trial and that he should be monitored.
34. He was remanded into custody by the Magistrates' Court on 23 May 2006 to stand trial. He was charged with murder and threats to kill. He was taken to HMP Liverpool, and admitted into the healthcare centre.
35. During late July and August, he attended trial at Crown Court. He was convicted of manslaughter on the grounds of diminished responsibility, and of threats to kill. Sentencing was adjourned to 15 September.
36. On 11 September, he set fire to his cell. He barricaded the door and said he had wanted to die. An ACCT was opened immediately. He displayed evidence of paranoia, delusional ideas and stress due to his forthcoming sentencing date, which had been identified as a potential trigger. He indicated that he had difficulty dealing with his feelings about being found guilty for the death of his partner, his sense of loss and not being able to see his son.

37. A medical assessment found that he was unfit to attend court, and he was reviewed again by the psychiatrist, who was also the visiting psychiatrist to the prison. He was prescribed antipsychotic medication, monitored closely and reviewed frequently. By 23 September, his mental health had improved and the ACCT was closed. In the post closure interview (an interview that takes place approximately a week after the ACCT is closed) he said he wanted to attend court for sentencing as soon as possible to get it out of the way.
38. In early October, a further ACCT was opened as he had paranoid ideas and was worrying about his sentence. The ACCT was closed a week later after he was assessed at hospital and reported no further suicidal ideas.
39. He was sentenced to an indeterminate sentence for public protection on 21 November 2006 at Crown Court. The judge set a tariff of a minimum three years imprisonment to be served before he could be considered for release by the parole board. In sentencing, the judge took account of a number of psychiatric reports. This included the psychiatrist's view that he had suffered a psychosis caused by recurrent stress in a person predisposed to psychosis as a secondary consequence of physical health problems that he was extremely sensitive to stress and was easily prone to further psychotic episodes.
40. Following sentence, he initially remained at Liverpool. A further ACCT was opened for eleven days in January 2007 after he refused medication and had thoughts of self harm. He was admitted to the healthcare centre and received further mental health in-reach team support. The ACCT was closed after he had contact with his family, accepted his sentence and had improved motivation.
41. He maintained progress at Liverpool. His father died in January 2008 and, after he attended the funeral, it was reported by staff that he appeared to manage his bereavement well. After initially relapsing into some drugs misuse he remained drug free, and achieved enhanced status under the incentives and earned privileges (IEP) scheme. (Under IEPS there are three levels, basic, standard and enhanced. The level a prisoner is on will determine the number of privileges he may have access to.) He undertook a short period of cognitive behavioural therapy<sup>1</sup>, and completed accredited programmes in addressing substance misuse related offending and victim awareness.
42. In February 2009, he was considered for release on parole. At the end of the month he received formal notification of the parole board's decision not to release him. They recommended that he completed both the Enhanced Thinking Skills (ETS) and Healthy Relationships programmes before he made another application.

### **The man's arrival at Risley**

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<sup>1</sup> Cognitive behavioural therapy is based on the theory that psychological symptoms are related to the interaction of thoughts, behaviours, and emotions. In cognitive behavioural therapy, the therapist and patient will work on identifying and directly changing thoughts and behaviours.

43. He was transferred from Liverpool to Risley on 20 March 2009. The prison record shows he understood this to be a progressive move to enable him to complete the ETS programme.
44. The reception cell sharing risk assessment (CSRA) assessed his risk to others as medium, and indicated that he should be allocated a single cell because of medical issues. The first night assessment identified him as having a history of hallucinations, depression and anxiety. He also had a history of illicit drug misuse, had liver disease (cirrhosis and evidence of liver malfunction) and secondary of alcohol misuse, hepatitis C and portal hypertension (high blood pressure). It was also noted he had previously received treatment for oesophageal varicies (complication of portal hypertension as a consequence to cirrhosis of liver). In this initial assessment no suicide or self-harm risks were reported, indeed he denied he had been under any previous ACCT procedures.
45. Healthcare Assistant (HCA) A undertook a full initial healthscreen on reception which identified the complex conditions from which he suffered. She identified the need for a mental health assessment, having recorded the basic facts of his mental health history. Prison Doctor A examined him on 23 March and, having assessed all his conditions, saw him again the following day. He recorded him as “chronically unwell though systemically stable” and followed up his outstanding hospital appointment with his gastroenterologist<sup>2</sup>.
46. He completed his two day induction programme on 24 March. He was then relocated to single cell accommodation on C wing.
47. On 21 April, the public protection casework section of the National Offender Management Service (NOMS) sent him a letter which advised him of the risk factors he should address before his next parole review. These included addressing drugs and alcohol, his emotional state, and violence and relationships issues. He was informed that the provisional date for the parole review was October 2010.
48. Medical records show he failed to attend for his first appointment with the mental health in-reach team on 15 May. A follow up appointment was made.
49. On 23 May, he presented himself to the emergency clinic in the healthcare centre with a facial injury. Although he said he had fallen and hit a snooker table, staff suspected that he had been assaulted. Checks were made and, because of his liver disease, he was given an appropriate painkiller. The following day he reported more severe swelling and he was sent by ambulance to the Accident and Emergency Department for x-rays. He was found to have a fractured jaw and was transferred to another hospital for surgery. A plate was fitted to help the jaw heal.
50. He was discharged from hospital and returned to Risley on 29 May. Prison Doctor A reviewed him on 1 June. The doctor reviewed his medication, and

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<sup>2</sup> The branch of medicine dealing with the study of disorders affecting the stomach, intestines, and associated organs

noted he had gained some weight and said that he had more energy and appetite levels. He admitted he had been assaulted and punched in the jaw but denied he was being bullied. A violence reduction investigation was carried out by prison security staff. This found that he had actually been goading a prisoner and had initiated the attack. He had however received the only injuries. The other prisoner was moved to a different wing whilst he was to be monitored. The matter was also referred to the police.

51. He presented himself again to the healthcare centre on 9 June, reporting he had fallen over and was concerned due to his recent fracture. Prison Doctor B saw him the following day and, finding some bruising to his jaw, ordered an urgent x-ray. No concerns were noted when the x-ray report was received a few days later.
52. On 17 June, he failed to attend a further rearranged mental health in-reach team appointment. He was, therefore, sent an "opt-in" letter for mental health in-reach services.
53. During July, he attended hospital for checks in relation to his jaw and abdominal pain, diagnosed as a consequence of his pancreatitis. He again failed to attend for an appointment with the mental health in-reach team and, as he had not returned the "opt-in" form, he was discharged from their waiting list and caseload on 14 July. On 30 July, Prison Doctor A undertook a full medication review following advice from his hospital gastroenterologist. The doctor noted that he was attending the gym, with improved muscle tone, balance and walking, and with improved mood. He also began working as a wing cleaner in October.
54. On 14 October, he attended for a mental health assessment. This was undertaken by the primary care graduate mental health worker. A history was taken, and the recorded assessment indicated he had consistent positive mood, good levels of activity, support from family, and that there were no indications of self-harm. It also recorded that he had expressed a great amount of guilt over his offence and death of his partner, about which he continued to experience nightmares. He said he was ready to discuss these issues. He was happy with the plan to refer for counselling to deal with the bereavement issues, and to discharge him from mental health services.
55. On 25 October, he was seen and examined by Nurse A after he was assaulted, being punched and kicked to his head, face and torso. Given concerns that he may have a further fractured jaw, he was taken by ambulance to hospital. He returned to Risley in the early hours and was given pain relief. A violence reduction investigation again took place. It showed that the assault occurred in his cell and was about a game of cards. He intended to press charges against his assailant and so the matter was also referred to the police. Staff recorded his positive behaviour and politeness to staff despite his evident pain. There was no further information about whether a change of location was considered for him.

56. For the remainder of the year, he did not attend any appointments with healthcare staff. However he did attend for a discussion with a nurse about treatment options for his liver condition and received further advice regarding his hepatitis C. Early in 2010, preparations began for his parole review.
57. On 10 March, Officer A, who had been appointed as the man's personal officer, recorded on NOMIS that the man conformed to the wing regime and achieved good work standards as a cleaner. He noted that "he associates well on the wing but can be upset at times when prisoners pull his leg".
58. A brief wing sentence plan review report by an officer, dated 3 March, noted that the OASys assessment<sup>3</sup> documented that he had mental health issues "but no evidence of this is seen so far on the wing". A similar report dated 24 March by Community Psychiatric Nurse (CPN) A, based only on records and a discussion with by Prison Doctor A, identified no medical or mental health issues. The CPN noted that, since he had stopped taking medication in 2007, he had presented as stable and, following one meeting with the graduate mental health worker, had been discharged from the mental health in-reach service.
59. On 5 April, a cell sharing risk assessment (CSRA) review downgraded his level of risk to low whilst he remained on C wing. Officer A recorded on 15 April that he had seen him with bruises to his arms and eye. He refused to explain how they occurred, insisting that he felt safe on the wing. He was reassured of staff vigilance. He did, however, indicate he tended to get depressed over not knowing his release date.
60. An Approved Mental Health Professional (AMHP) from the criminal justice liaison team in Knowsley-St Helens, met him on 20 April to undertake a mental health review at the request of his home probation officer. In her report, dated 5 May, she found that he "presented as stable in mood and did not display any signs or symptoms of mental disorders". She reported he had feelings of guilt and remorse, but that he did not feel overwhelmed by these, and while not minimising the offence he showed lack of insight into its impact on others.
61. The man's home probation officer submitted a parole assessment report dated 5 May. He reported that he had completed a number of programmes including the enhanced thinking skills programme and was waiting an assessment for the controlling anger and learning how to manage it (CALM) programme. He assessed him as having an "ongoing lack of insight and understanding into the impact of his offence"
62. On 13 May, the NOMIS record shows that he had been cleared by prison security for particularly trusted work in the prison gardens. He was also interviewed by a seconded probation officer at Rislely for a parole report. In her report, she outlined the number of programmes he had completed, and that he was about to receive additional counselling. She drew on reports that his mental health was much improved and that he had tested as drug free for some

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<sup>3</sup> Offender Assessment System is a document used for assessing risk of harm and re-offending.

years. She reported that he had referred himself for the CALM programme, although it had not been identified as a sentence plan target, but that she doubted his suitability for the programme.

63. He saw the bereavement support worker from a Bereavement Support Group for the first time on 9 June. She told the investigator that there was quite a waiting list for prisoners wanting bereavement support and their staff resources had been reduced. She also only worked one day a week in the prison. She continued to see him on a regular basis, last seeing him on 9 November. She told my investigator that he seemed “absolutely devastated” when discussing his partner’s death and frequently discussed concerns for his son.
64. At the end of June, his solicitors submitted his representations to the parole board. He argued that he should move to open conditions if he was not released.
65. By early August, he was increasingly worried over the offending behaviour programmes he would be required to attend. On 7 August, Officer A recorded he had to reassure him on several occasions, and that he would arrange for his offender supervisor to see him.
66. On 10 September, the seconded probation officer re-interviewed him for an addendum to her original parole report. This report clarified two issues. Firstly, the treatment manager for the CALM programme had assessed that, given his offence, he should undertake the Healthy Relationships programme (HRP), for which he would have to transfer to another prison, prior to any referral to CALM. Secondly, assessments indicated that he “does not, at this time, require any further mental health interventions”. She also reported that he had attended six one day courses run by the CARAT team over the summer, and had participated in other positive activities. Given that his home probation officer believed that he should complete both the HRP and CALM programme whilst in custody, she concluded that she could not support either his release or a progressive move to open conditions at this time.
67. On 22 September, an IEP review board chaired by a Senior Officer (SO) A downgraded his status to standard under the IEP scheme as he had been unemployed since May. (There was no indication why he had ceased work.)
68. By the end of September, the records show that he was becoming increasingly worried about the offending programmes he was required to complete. It was recorded on NOMIS on 29 September that he was disputing the need to complete the CALM programme. On 4 October, he asked Officer A whether he had to undertake the HRP programme, accusing the Prison Service of “stitching him up”. The officer arranged for his offender supervisor to see him.
69. At interview, the offender supervisor said that he spoke with him about a “dozen” times about CALM and HRP. Their discussions revolved around which course he had to undertake, and the long waiting times for courses. The offender supervisor had said he would look into this and try to get a definitive answer. The man was anxious as this had a knock on effect on his parole

hearings and ultimately his release from prison. He also said he was also concerned about not being able to see his son.

70. The offender supervisor said that there was also confusion over the parole hearing date. The man's details had apparently been listed incorrectly and a date was still outstanding.
71. On 27 October, SO B telephoned CPN B regarding concerns about his low mood. When he was speaking he was also not making much sense. The CPN had said that if she had concerns then maybe the ACCT procedures should be instigated. SO B told the investigator that she had no concerns that he would harm himself and after discussion it was agreed that an appointment for him to see the doctor would be made.
72. The following day, NOMIS records show he met with Officer B. He said that people were talking about him and his offence. She described him as "very paranoid and jumped from one subject to another". He would not identify the specific prisoners who were talking about him and said he did not want to move wings or be transferred to another prison given the imminence of his parole hearing.
73. Prison Doctor A saw him as arranged in the morning of 29 October. He described being in low mood for a month and that he had been thinking about his crime and that his partner had died. The doctor diagnosed low mood and insomnia and reviewed his medication. However, due to his concern about his mood, he arranged to see him again in the afternoon together with CPN C to undertake a mental health assessment.
74. He attended again in the afternoon. He said that he had vomited during the lunch time period and said he could hear voices in his cell and that people could read his thoughts. He also described his worries over his parole application. CPN C recorded he was possibly mentally ill, although he only half believed that people could read his thoughts. Nevertheless, he found an element of paranoia as he thought there were people talking outside the consultation room when nobody was there.
75. Although he denied having any thoughts about harming himself, CPN C decided to open a precautionary ACCT document given his confusion, sensitivity and stress. The CPN recorded on the ACCT that he presented as mentally unstable, stressed and paranoid and may be mentally as well as physically ill and worried about his parole. Prison Doctor A recorded a diagnosis of stress and adjustment reaction, and decided to refer him to hospital to exclude any natural causes of possible psychosis. He also prescribed olanzapine 5mg (an antipsychotic medication) and mirtazapine 30mg (an antidepressant sedative used to support sleep) on his return.
76. ACCT procedures were implemented with immediate effect and he was placed on a minimum of half hourly observations. He was taken to hospital for tests and the ongoing ACCT record shows he responded to questions in a "calm and controlled manner". He returned to Risley late in the evening and told staff he

was “ok”, that he thought he had got on the “wrong foot with people on C wing” but felt settled there, and gave staff no cause for concern.

77. On 30 October, SO A reduced his observations to hourly in the morning pending review. Later, Officer C undertook an assessment interview with him recording that he felt stressed about his imminent parole review which was causing him to remember his crime. He denied thoughts of self-harm, indicating that support from his family was his motivation. He said having talked about his issues he felt better, and the agreed plan was that he should talk to staff. He was reminded of the ‘Listeners’ on the wing.
78. SO A undertook the required ACCT case review with him and a wing officer in the afternoon. Given he had made it clear he had no intentions of self-harm and that he felt better having talked his problems through, it was agreed to close the ACCT. He was advised to speak with staff more and the SO said he would contact his offender supervisor for an update on his parole review.
79. On 1 November, CPN C referred him to see the visiting psychiatrist. The following day the mental health in-reach team agreed to take him as a priority referral. The CPN saw him, having heard the ACCT had been closed, for a further assessment in the afternoon and decided to take him on his caseload. He appeared better, denied any self-harm ideas or hearing voices, but said he had been stressed. He told the CPN he kept thinking about his offence and that he was receiving bereavement counselling. He was reluctant to see the psychiatrist but agreed to do so. The CPN recorded his view there were elements of agitation and paranoia, and that he felt “we [medical staff] will fill him full of medication”.
80. The CPN met him again briefly on 3 November. On this occasion he admitted that he had mental health problems at the time of his offence and realised he needed support, even if this meant he had to be transferred into a semi-secure unit. The CPN reassured him this was not currently planned.
81. The ACCT post closure interview with him was undertaken by SO B on 6 November. She recorded that he was much better, his main worry being the parole hearing which had been put back on three occasions. He did, however, admit he was scared of being released without support mechanisms but she reassured him that he would not be. He also told her he was seeing a mental health assessor during the week which would enable him to have proper discussion about his mental health worries. He said he was happy with the support given to him by staff and prisoners on the wing, and he had no plans to harm himself.
82. He was taken on as a wing cleaner again in early November. On 12 November, his IEP status was restored to enhanced. The same day, he was seen by Prison Doctor A for a review. The medical record shows he presented as less anxious and stressed, and admitted he had stopped taking his antipsychotic medication three days previously as it made him drowsy. He said he had suffered from insomnia over several weeks due to his worries about his parole review. The doctor found him apparently rational with no evidence of

psychosis or paranoia. He was reluctant to take any long term medication despite the doctor trying to persuade him. Given his was reducing his antipsychotic medication (olanzapine), the doctor prescribed temporary medication for his insomnia, and arranged for a further review with CPN C.

83. A NOMIS entry on 15 November by Officer A said that the man had been less paranoid and happier over the previous three weeks after being taken back as a wing cleaner. His work was acceptable and undertaken with little supervision.
84. CPN C reviewed him on 17 November. He noted his wish not to take antipsychotic medication anymore, and that he looked better with more insight. Although he “seemed a little guarded”, he denied hearing voices or having excessive paranoia although he discussed his insomnia, and pressure over parole. The CPN agreed to refer him for a medical review in two weeks, to contact the AMHP regarding his parole, and to see him periodically to ensure his mental health was maintained.
85. The NOMIS record by SO A shows that, on 21 November, some prisoners saw him with concerns that he was “cracking up”. The SO talked with him in his cell but, although he had some concerns, these were not “major”. He arranged for the CPN to see him the following day.
86. The wing observation book records that, just before midnight, Officer D responded to hearing him kicking and punching his cell door. He recorded his behaviour as “out of character” and “very strange”. He was shouting out to other prisoners threatening to kill them because they had killed his family and he was not to blame for the crime he had committed. He also talked as if he was responding to people who were not, in fact, speaking. Eventually, he responded to the officer, telling him to get his team and threatening to stab the first person who went into the cell. He declined the offer to see healthcare staff. The officer informed the senior night orderly officer, who attended and informed healthcare staff to ensure the mental health in-reach team saw him the morning.
87. The officer maintained checks over a 45 minute period by which time the man had calmed down, apologised to him and said he was going to get some sleep. The officer reassured him and encouraged him to speak with staff. Further checks were made through the night and he was observed to be in bed making strange noises and not responding. He finally went to sleep at 4.30am.

### **Events of 22 and 23 November**

88. In the morning of 22 November, CPN C contacted SO C on C wing and was briefed about the man’s behaviour. He informed the SO that he had been calm and appropriate the last time they met, but he was refusing to take his medication and he would try to get him to do so. An officer tried to open the door and speak with him, but stopped when he lunged at him.
89. The Departmental Prison Service Manager (DPSM) and CPN C were asked to attend a case conference together with two SOs and the man at approximately

10.00am. He agreed to attend the meeting. SO C recorded that he was initially defensive and aggressive, but was calm and open to positive suggestions by the end of the meeting. He admitted he was angry and had aggressive thoughts about other prisoners and felt unsafe on the wing, but agreed to restart taking his medication and see a psychiatrist. The CPN recorded him to be oriented to time, people and place, with normal speech, appropriate eye contact and denying thoughts of self-harm or harm to others. However, he seemed confused and distracted and mentioned negative thoughts including bad dreams about his family being murdered and hearing voices from outside his cell.

90. The DPSM recorded the meeting and agreed to place him in the Care and Separation Unit (CSU) to give him time away from others, to reflect and to restart taking his medication before returning to the wing. He agreed to this plan as he felt threatened by others. On route back to his cell, the CPN said that some of the other prisoners asked him if he was ok, to which he responded "fuck the lot of you". The CPN was concerned about this response and thought that he may need time out to reflect.
91. Following his return to his cell to prepare to move, the DPSM recorded that his suitability for the CSU was discussed and agreed as a good move for him currently given his attitude to other prisoners and as an opportunity to restart his medication and settle down. It was decided to refer him to the psychiatrist, who was due to visit Risley in three days time, and to consider his possible referral to the inpatient unit at HMP Preston. SO C recorded that the meeting also decided not to open an ACCT document.
92. Two DPSMs completed the required authorisations for segregation in the CSU under Rule 45 OI (meaning segregation in "own interest") due to a "deterioration in his mental health". When all the paperwork, including the required initial segregation health screen, was completed, it was seen and countersigned by the duty governor. He was taken to the CSU at approximately 10.15am.
93. CPN C completed the initial segregation health screen (which alerts staff to any health reasons why segregation is not appropriate) within the required time. The screen consists of a health algorithm (a tool used by clinicians for assistance with decisions making) and the CPN indicated he did not think his mental health would deteriorate significantly if segregated and that he would be able to cope with segregation. However, he did indicate he was showing signs of being acutely unwell, concluding the algorithm by ticking the "no healthcare intervention at this time" box. The CPN also believed that in the CSU prisoners would be monitored hourly throughout the night.
94. The man's medical record shows that CPN C received a telephone call from the psychiatrist from the clinic. She told him that she had received a call from the man's sister who was concerned about his mental state. The CPN updated her and she had advised there could be an organic cause (causes of symptoms of mental illness classified as organic disorders are those caused by physical illness affecting the brain) which would need to be excluded before he could be

referred back to the clinic. The psychiatrist also asked the CPN to check his medical notes to confirm which appropriate antipsychotic medication could be used given his liver disease.

95. The chaplain visited him at 10.20am in the CSU. The chaplain recorded in the wing observation book that he was in bed and covered up saying he was fine but tired and would like to sleep.
96. The CSU segregation history records show that he collected his lunch and hot water at 11.45am. He was observed to have pulled his shirt over his head "trying to hide" on the way back to his cell.
97. Officer C in the CSU spoke with him at 2.10pm. He told her that he was "ok", that he needed time out of his cell and some sleep, and said "he has sorted his head out now".
98. CPN C saw him briefly in his cell at 3.00pm. He told him that the psychiatrist had called because his sister had contacted her, and informed him he had been listed to see the visiting psychiatrist during the week. He recorded in the medical record that he told him he did not want to see the psychiatrist and did not want his medication, but had made no threats. In the CSU history sheet, he described him as "guarded/paranoid and has an edge to him". The CPN also made an entry in the wing observation book highlighting the information that he had set fire to his cell when ill in the past and requesting staff to "please be vigilant to this as we try to get more details".
99. At around 4.00pm, having being told that he was in CSU, the Offender Supervisor went to see him to see how he was. He opened the cell door and observed him lying on his bed, covered. He did not respond to him when he spoke to him and he was unsure if he was sleeping or simply just did not want to talk.
100. At 4.45pm, CSU staff recorded that tea had been served to him and there were "no issues". Similarly, at 7.00pm staff recorded there were "no issues" with him.
101. Officer C told my investigator that, when she started night duty on the CSU, she was briefed about him at the 7.30pm handover. She then undertook a roll check of prisoners on the wing, observing him in his cell at about 7.55pm. She recalls he was sitting on his bed with his feet up. She does not recall him acknowledging her when she opened the observation panel.
102. She undertook patrols around the CSU during the night at irregular intervals, and also observed another prisoner on an ACCT document on three occasions. At no time did she hear or see anything from his cell which caused her to look in his cell.
103. At 5.30am, she opened the observation panel into his cell as she was undertaking the routine morning roll check. Unable to see him in bed, she turned on the night light and saw him suspended by a ligature from the window. She immediately used her radio to call for emergency assistance from "Oscar

1”, the night orderly officer, and from a nurse, repeating the transmission as there had been a disruption to the call. She did not, however, use the recognised emergency code. She also shouted for assistance to Officer E, who was nearby in the connected E wing.

104. He arrived within a minute and, together with her, they opened and entered the cell. He held the man while she cut the ligature. SO D, the night orderly officer, arrived shortly afterwards, as did Officer F, and they assisted laying him on the bed. The SO had instructed a patrol officer to collect staff Nurse B and they arrived a few minutes after the first call with emergency equipment. Although the nurse was not aware of the type of incident that she was to attend, she told the investigator that she decided to bring all the emergency equipment.
105. The nurse said she could see as soon as she entered the cell that rigor mortis had already set in from the colour of his body and lack of movement. She still, nevertheless, undertook checks for vital signs but could find no pulse, circulation, or breathing. She was unable to gain access to his airway.
106. An ambulance had already been called and, after a brief telephone discussion with the nurse while they were en route, the paramedics arrived at the cell at approximately 5.46am. They undertook a heart trace and, finding him asystolic (a state where there is no cardiac electrical activity in the heart) with no heart beat, pronounced at 5.55am that he had died.
107. The SO had earlier called the prison’s control centre to activate the death in custody contingency procedures, and asked Officer F to keep a log of events. Staff left the cell. Shortly after 6.00am the police arrived and checked the cell and subsequently, following their request, the cell was secured at 6.27am. He was released to the undertakers at 12:35 pm.
108. The duty governor co-ordinated the prison’s death in custody action plan. The record shows that all required actions and relevant organisations and personnel were informed of the man’s death in a timely, considered and efficient manner.
109. A ‘hot debrief’ of staff immediately involved in responding to the emergency was undertaken by the duty governor. As these were night staff, this debrief was undertaken on an individual basis. The attending staff nurse was debriefed by the head of healthcare separately. A ‘critical incident debrief’ was also organised subsequently, and staff were offered care team support.
110. A review of all prisoners under ACCT procedures was undertaken. Particular care was taken in informing other prisoners on the CSU and support was offered to them. Later, a notice to all prisoners informing them of the man’s death, signed by the Governor, was posted. They were also advised of the support available and of the memorial service to be held the following day.
111. A governor grade was appointed as the family liaison officer (FLO) at 7.00am. She immediately attended the prison for a briefing. Both the FLO log and her interview with my investigator show that she attended the man’s mother’s home with the co-ordinating chaplain, at 10.40 am. The man’s brother arrived within

ten minutes and he was informed of his brother's death before he contacted his mother, who was shopping. When she returned home at 11.40am, she was informed of her son's death by the FLO. Similar care and consideration were taken in ensuring both his sisters were informed during the day.

112. The FLO liaised with the police, who were acting on the coroners, on behalf with the family. They were able to see him prior to the post-mortem arranged for 24 November. The FLO telephoned the man's mother on 24 November offering support and visited the family again with the chaplain the following day taking a letter of condolence from the prison Governor, cards from prisoners on the wing as well as an order of service from the prison's memorial service. The family were offered financial assistance toward funeral costs and it was agreed the Catholic prison chaplain would conduct the funeral.
113. Both the prison Governor and the FLO attended the man's funeral the following week.

### **Post mortem**

114. The post mortem results confirmed the cause of the man's death as primarily due to compression of the neck by hanging.

## ISSUES

### Clinical Care

115. I am grateful to the clinical reviewer, on behalf of the local NHS Trust, for undertaking a clinical review into the man's care whilst at Risley. This review found that he received care of a standard which was equivalent to the care which he would have received had he seen healthcare professionals in the community. He makes one recommendation which I cover in my findings below.

#### *The man's mental health*

116. There were some indications that the man's mental health was deteriorating in the weeks leading up to his death. He was recorded as becoming very stressed over his parole hearing, especially because of delays and the possibility of having to take further offending programmes. For some reason, there appeared to be some ambiguity in the information that was relayed to him. Certainly at the time of his death, the date of his parole hearing and the details of what offender programmes he had to complete were still outstanding.

117. In previous death in custody investigations, I have come across prisoners with IPP sentences who have experienced bouts of anxiety as a result of not knowing information which ultimately affects their release from prison. It is important that staff from different departments communicate quickly, effectively and accurately this type of information to prisoners, to alleviate concerns they have.

**The Governor should ensure that all IPP sentence prisoners are provided with clear, accurate and up to date information on their sentence progression and parole dates.**

118. Prison Doctor A and CPN C assessed him on 29 October and, following concerns that he may be mentally ill, he was prescribed antipsychotic medication and an ACCT was opened. He was also assessed at hospital to exclude any underlying organic causes of psychosis. He was taken on to the mental health in-reach team's caseload and placed on the waiting list to see the visiting psychiatrist.

119. He then quickly seemed to have improved, responding rationally and appropriately. At his own request, after he admitted that he had stopped taking it, his antipsychotic medication was stopped during his review with Prison Doctor A on 12 November. He was still prescribed medication for his insomnia. He reiterated his wish not to take antipsychotic medication to CPN C on 17 November, and there is no evidence he was subsequently prescribed any antipsychotic medication.

120. Officer D then became aware of his uncharacteristic and threatening behaviour in his cell near midnight on 21/22 November. The senior officer informed healthcare, but as there is no out of hours mental health service, the discipline

staff could only ensure the mental health in-reach team were requested to attend in the morning. Wing staff managed the situation until then. The officer, in particular, kept him under observation and should be commended for his role in seeking to calm him down and ensure his safety.

121. I am not satisfied, however, that there was no out of hours mental health service to support wing staff at night and to assess and take whatever action is necessary to maintain a prisoner's mental health. There remains an outstanding recommendation in this area from HMCIP and I wish to reinforce that recommendation to the Governor and Head of Healthcare at Risley, namely that:

**The Governor and Head of Healthcare should ensure systems are in place for the management of out of hours mental health emergencies.**

### ***Bereavement counselling***

122. Having been referred for bereavement counselling, the man had to wait around eight months to be seen by a counsellor. My investigator was told that there was a long waiting list of prisoners wanting to see a counsellor and along with a reduction in the counselling service provider's staff resources, this caused a delay. Whilst he did appear to benefit from his counselling sessions, the timeliness of such support mechanisms is vastly important in aiding healthy living and recovery in the short and long term of a prisoners well being. I would suggest that the Governor and Head of Healthcare review the bereavement services being provided with a view to ensuring alternative support is available in the interim whilst prisoners await their appointments.

**The Governor and Head of Healthcare should review the services offered by the bereavement counselling services and ensure prisoners referred to such services are seen in a timely manner.**

### ***Locating the man in the Care and Separation Unit***

123. His uncharacteristic and threatening behaviour on the night of 21/22 November led to the decision to segregate him in the Care and Separation Unit under Prison Rule 45 (PR45-OI) in his own interest. He agreed to this course of action. This decision had some justification under the Prison Service Order (PSO 1700) governing such situations which states,

“The prisoner may also exceptionally request own interest segregation for reasons other than a fear of assault by other prisoners eg genuine inability to cope on normal location for a specific time period (eg mental health reasons, period of stress / bereavement, with home domestic circumstances)”.

124. The CSU record gives the reason for his segregation as a “deterioration in his mental health”.

125. The DPSM chaired the multi-disciplinary case meeting, which included the man, in which the decision to place him in the CSU was made. He met most of the criteria outlined in PSO 1700. He had, in the past, been subjected to a serious assault. His threatening behaviour during the night (which was repeated to a lesser extent in the morning) put both staff and other prisoners' safety at risk as well as, potentially, his own safety on the wing.
126. PSO 1700 does require consideration of other options other than segregation, as well as an assessment as to whether the prisoner's mental health may deteriorate in segregation. In his circumstances, this was particularly pertinent. I am concerned, however, that services available at Risley provide a too limited range of options for operational managers seeking to safely manage the kind of challenges and circumstances present in his case.
127. One option, for example, would have been to keep him on the wing in normal location, but with additional support given his deteriorating mental health. However, this option was not available as Risley has no day care provision to support prisoners with mental health problems who are less able to cope on the wings. Both Her Majesty's Chief Inspector of Prisons and the IMB, in their last reports, have highlighted this gap in provision. Given the numbers of prisoners at Risley with indeterminate IPP sentences, and those with mental health problems, this lack of provision is not acceptable. HMCIP has already made a recommendation to Risley in this regard. Whilst not repeating it, I reiterate it and wish to reinforce the priority which the prison and the local mental health trust should give to implementing this recommendation.
128. As Risley has no in-patient unit, this also was not an option. There was the possibility that he could either have been transferred to the in-patient facility at HMP Preston or transferred under the Mental Health Act to the secure unit at the clinic. There is evidence that a transfer to Preston was under consideration and that a transfer to the clinic had been discussed at an initial stage during the telephone call made by the psychiatrist to CPN C. Either of these may have been the outcome of the mental health assessment by the visiting psychiatrist which had been organised for 25 November. The CPN told my investigator that even if the request for transfer had been initiated earlier, given the time required for medical assessment and agreement, it was still likely that the man would have been located in the CSU on the 22/23 November. I am pleased the decision was taken seriously, and considered by a multi disciplinary team. The multi-disciplinary case meeting, therefore, had few other options than to agree segregation.

### ***Levels of observation in the CSU***

129. CPN C told my investigator that segregation of prisoners with presenting mental health problems has been used a number of times in order to provide "time out" from the wing. In addition, as the CSU was visited daily by a nurse and three times a week by the medical officer, any further deterioration in the man's mental condition was more likely to be identified there. However, the CPN thought that prisoners in the CSU were observed on an hourly basis throughout the night, and this was not the case.

130. The man was only observed on an infrequent recorded basis whilst in the CSU and was not subject to ACCT procedures. Because of CSU's small size and higher staff to prisoner ratio compared to normal residential wings, it was also easier for staff to monitor him. The last recorded engagement with him was at 7.00pm, although he was seen through the observation panel by Officer C undertaking the first night roll check at approximately 7.55pm. As such, he was not observed for a period of over nine hours. Whilst this is standard practice for most prisoners on normal residential wings, it should certainly not apply to those whose mental health has been described as "deteriorating". I take note and welcome the fact that Risley has since revised its segregation policy and that all prisoners located in the CSU are now observed on an hourly basis for the first 24 hours.

### ***CSU Segregation Health screen Algorithm form***

131. The initial segregation health screen is the required first step in identifying which prisoners may be most vulnerable. It consists of a structured algorithm leading to one of two conclusions, either "no healthcare intervention at this time" or "there are healthcare reasons not to segregate at this time". In the man's case, to the question whether "the prisoner shows signs of being acutely unwell (eg. psychotic/withdrawal from drugs/significant physical injury) at the present time", CPN C ticked "yes". When "yes" is ticked at this stage, the logic and structure of the algorithm concludes there are healthcare reasons not to segregate at this time.

132. Despite this, the CPN felt that the man would be able to cope in the CSU environment. From looking at the algorithm form, it is unclear how this decision was reached. The multi-disciplinary case meeting agreed to the segregation and interviews with staff show that this was to give him the opportunity away from his cell and wing. This would help him to reflect, give time to consider a transfer to Preston, receive an assessment by the psychiatrist, think about restart taking his medication, with a goal that he return to normal location. However, no contemporaneous minutes or record of this meeting and its decisions were taken, nor was this plan of action adequately summarised on the necessary CSU record authorising segregation.

133. HMCIP's last inspection of Risley found that some initial segregation health screens had been completed incorrectly, as this one was, and made a recommendation that safety algorithms "should be fully completed by healthcare staff". The initial segregation health screen is an essential tool to identify those prisoners whose vulnerability requires additional assessment, planning and support and it is important mistakes should not be made in its completion.

134. The CPN did however provide a detailed briefing at the healthcare team's handover meeting on 22 November, which included the healthcare manager and doctor. He said that the man's mental health was deteriorating and discussed what medication he could receive given the possible effects on his physical health. There is no evidence, however, that this meeting addressed

the issue of whether to they should support his move to segregation. Further, given no decision was made on what antipsychotic medication could be prescribed for him, there is no evidence that they considered other means of supporting his mental health whilst segregated. I consider this was a missed opportunity to ensure an explicit plan to support his mental health within the Care and Separation Unit was devised and shared with the discipline staff.

135. This replicated an earlier missed opportunity. The case meeting deciding on segregation had, as mentioned above, a plan of action in mind. However, this was not adequately recorded on the CSU record, nor was it sufficiently specific and it failed to consider a required part of the segregation process. PSO 1700 requires as part of the process of segregation that,

“All prisoners located in the segregation unit must be observed by an officer at a frequency which is relevant to the individual’s circumstances and will be based upon a case management approach. The observation level should be decided by the person authorising segregation”.

It further advises that prisoners unfamiliar with segregation may need to be observed more regularly “which ideally would be at least hourly”.

136. The plan of action should have explicitly stated what level of observations the man needed in order to support his mental health whilst segregated. The only element of a plan in the CSU record simply states “stabilise his medication with a view to returning to the wing”. A case management approach to segregation, particularly in respect of “own interest” segregation, needs to be supported by a clear plan in the CSU record which contains specific, measurable, achievable, realistic and time limited objectives. Such a plan would enable staff to provide the desired level of care and support by reviewing and identifying progress and concerns on an ongoing basis.
137. I understand that Risley have been undertaking a review of their segregation policy. I make the following recommendations to be considered in that review:

**The Governor and Head of Healthcare should ensure that all staff implement the required process of segregation described in PSO 1700. This should include reminding staff to accurately record the reasons why prisoners are placed in segregation and ensuring that the structure of the safety algorithm is correctly followed.**

**The Governor should ensure that when segregation is authorised, the CSU record contains a specific action plan and that staff review progress against this plan.**

### ***Assessment, Care in Custody and Teamwork (ACCT)***

138. The man was placed under ACCT procedures on one occasion while at Risley, at the end of October 2010. This ACCT plan was opened and closed appropriately.
139. The case meeting held on 22 November, following his uncharacteristic and threatening behaviour in his cell the preceding night, did consider whether to open a further ACCT plan. It was decided not to open one. There is no evidence that he made any threats of self-harm or suicide either during the night or the following day. Although his behaviour was threatening and uncharacteristic, the threats made were towards other prisoners and to staff. He was assessed during the case meeting as being more appropriate although vague and contradictory. He told staff he feared for his safety, but this related to hearing voices of prisoners outside his cell which he did not recognise. There is no evidence that any prisoners who had previously assaulted him were present on the wing.
140. During the case meeting, he denied having any ideas of self-harm or suicide, and there is no evidence that he expressed any such ideas while in the CSU. Given this, I consider the decision not to open an ACCT plan was justified.

### ***Emergency Response***

141. The response to Officer C's call for emergency assistance was undertaken in a rapid and professional manner. There is evidence that both discipline and medical staff undertook all they could in responding to the emergency and that they treated him with consideration and respect.
142. The officer admitted to my investigator that, due to some panic on her part, she failed to use the recognised "Code black" emergency code during her radio call for assistance. This is understandable in the circumstances and it is noted she took all possible action to secure emergency assistance. This failure did not, result in any delay to either discipline or clinical staff responding urgently with necessary emergency medical equipment. SO D spoke with her afterwards about using the emergency code.
143. However, both staff who were first on the scene, Officers C and E, told my investigator that they had not received first aid training. I consider it essential that uniformed prison officer staff, who are usually the first responders to medical emergencies, have up to date first aid training which enables them to start CPR. I refer to a letter written by the Chief Executive of NOMS, and dated 29 October 2010, to all prison governors. The letter highlights the need for each establishment to review their first aid arrangements for prisoner-related incidents and, where inadequacies are identified, action plans must be put in place with timescales to remedy the situation. Whilst sadly this was not required in the man's case, I do make this recommendation.

**The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties.**

### ***Critical Incident Debrief***

144. The procedures following a death in custody were implemented promptly and effectively. Staff at Risley responding to the emergency were given an individual 'hot debrief' which was appropriate given they were night shift staff. Staff informed the investigator a subsequent 'critical incident' debrief was held, and that they received appropriate support from the care team. I note that Risley, in subsequently implementing hourly observations for the first 24 hours of a prisoner's segregation, have responded appropriately to the circumstances of the death and, in reviewing their policy on segregation, have continued to learn from it.

### ***Family Liaison***

145. Following his death, staff at Risley informed the man's family in a considered and timely fashion. Compassionate and professional support was offered and given to the family by the family liaison officer. This included liaising appropriately on their behalf in regard to the coroner's procedures, assistance with and attendance at the funeral, and informing them of the memorial service held at Risley and the condolences of fellow prisoners. The family have expressed their appreciation for this support.

## CONCLUSION

146. From his arrival into prison custody it does appear that the man found it extremely difficult to come to terms with the offence he had committed. As a result of this he subsequently received a lot of support physically and mentally during his custodial period. He also received bereavement counselling for a period. Yet in spite of this and the fact that he was considered and assessed as a low risk of self harm, staff had concerns about his mental health which, shortly before his death, was described as deteriorating.
147. It is difficult to suggest staff could have done more for him in a prison setting. Staff intervention the morning before his death appeared to be timely and indeed appropriate. However, given staff concerns about his mental health, it would have been appropriate to have had in place an agreed monitoring schedule for him. This is not to say that the outcome would have been different, but it would have reduced the period of time that he went unchecked during his first night in CSU.

## RECOMMENDATIONS

1. The Governor should ensure that all IPP sentence prisoners are provided with clear, accurate and up to date information on their sentence progression and parole dates.

**The National Offender Management Service accepted in principle this recommendation, writing:**

“IPP Prisoners are in scope of phase 3 of Offender management and as such it is the responsibility of the National Probation Service to complete their Oasys review and set sentence plan targets. However, we will work closely with the Offender manager to try to ensure that they meet their statutory obligations within the correct timescales. Prisoners will be provided with their parole dates and progression of their Parole dossier by the Prison.”

2. The Governor and Head of Healthcare should ensure systems are in place for the management of out of hours mental health emergencies.

**The National Offender Management Service accepted this recommendation, writing:**

“The local PCT commissions the mental health services for HMP Risley from 5 Boroughs Partnership. The Head of Healthcare at HMP Risley works with the commissioner at the PCT to address requirements from this service. An “out-of-hours” on call system was introduced in January 2010. This arrangement was in place at the time of the man’s death in November 2010. All mental health emergencies would be managed through this service and jointly with the staff on duty in Healthcare.”

3. The Governor and Head of Healthcare should review the services offered by the bereavement counselling services and ensure prisoners referred to such services are seen in a timely manner.

**The National Offender Management Service accepted this recommendation, writing:**

“Bereavement counselling at HMP Risley is a small, voluntary service, comprising 1 x Bereavement counsellor and 6 x Person-centred counsellors. As such there are capacity issues (i.e. only 1 bereavement counsellor). Prisoners are made aware of the fact that they may have to wait some time before a counsellor is assigned to them. That being said, the Counselling and Bereavement Support Service manages their waiting lists on the basis of a risk-based prioritisation system. If a prisoner is deemed by either himself or a staff member to constitute an imminent risk to himself or to others then he will be prioritised. In the case of the man it is acknowledged that he was on a waiting list for some time. He was visited by the co-ordinator of the Counselling and Bereavement Support Service and he indicated that he was content to continue in his referral. He was subsequently assigned to his bereavement support

counsellor. At no time was he flagged to the Counselling and Bereavement Support Service as an imminent or increasing risk."

4. The Governor and Head of Healthcare should ensure that all staff implement the required process of segregation described in PSO 1700. This should include reminding staff to accurately record the reasons why prisoners are placed in segregation and ensuring that the structure of the safety algorithm is correctly followed.

**The National Offender Management Service accepted this recommendation, writing:**

"Healthcare staff have been reminded of their part of the implementation the safety algorithm with particular reference to the guidance in PSO 1700 Where necessary training needs have been identified and addressed."

5. The Governor should ensure that when segregation is authorised, the CSU record contains a specific action plan and that staff review progress against this plan.

**The National Offender Management Service accepted this recommendation, writing:**

"More specific Action Plans were implemented immediately after the Death In Custody of the man. A new Segregation History Sheet Booklet was introduced requiring monitoring and recording of immediate concerns, First Night / 24 Hour Checks and comments by Healthcare etc. Daily Observations and Comments were recorded if the prisoner remained on Croft Unit. This new case management file forms the basis for continued monitoring of prisoners who remain on the unit under R45 GOOD or OI and action plans form the basis for subsequent segregation case reviews."

6. The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties.

**The National Offender Management Service accepted this recommendation, writing:**

"In July 2011 a full holistic first aid assessment of need to identify high, medium and low level risk areas and train relevant number of staff appropriate to the level of risk was undertaken. This is an annual review, the full assessment of need breaks the training down to full first aid trained staff and emergency first aid at work staff covering both day and night duties. HMP Risley currently have 12 members of staff to train in 2011 for first aid at work and 3 night staff in emergency first aid at work to be trained. There are currently 5 staff trained on nights in emergency first aid at work and one fully trained in first aid."