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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP  
Birmingham on December 2013**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanging in his cell in HMP Birmingham's healthcare unit in December 2013. He was 33 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the care that the man received at Birmingham. The prison cooperated fully with the investigation.

The man had been remanded to Birmingham for just over a week before his death, charged with a violent offence. During his second evening at the prison, he tampered with the electricity circuit and staff began managing him under suicide and self-harm prevention procedures a few hours later. Due to concerns about his mental health, he was moved to the prison's healthcare unit the next day. Entries in his clinical records suggest that his mental health began to improve after a few days in the healthcare unit.

When staff checked the man at 8.30pm one evening in December, he was lying out of sight, under a blanket, behind his bed. A nurse and an officer went into his cell but he would not move from where he was lying. Although he was required to be observed twice every hour, he remained unable to be seen behind the bed and did not respond to staff for nearly two hours before the night manager was called to open the cell so they could check his wellbeing. The night manager thought he saw him move, but did not establish that he was alive and well before attending to another prisoner who appeared to be ill. When the staff went back to his cell and checked him properly, they pulled back the blanket and found he had strangled himself using a strip of material torn from a bed-sheet.

The investigation found some flaws in the operation of suicide and self-harm prevention procedures which the prison will need to address. In particular, I am concerned that the man was not observed as he should have been on the evening of 19 December and that staff should have notified the night manager earlier that he was out of sight in his cell and not responding when checked. When the night manager arrived, he should have properly checked the man's wellbeing before going to attend another prisoner who needed his help. I am pleased to note that the healthcare beds are now being repositioned to eliminate the blind spot where the man lay hidden from view. It is also a concern that staff did not follow the required procedures for notifying a medical emergency, but an ambulance was called quickly.

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

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

**September 2014**

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## SUMMARY

1. The man was remanded to HMP Birmingham on 10 December 2013, charged with a violent offence. He had been in the prison before and had previously been managed under Prison Service suicide and self-harm prevention procedures (known as ACCT). He was not identified as at risk when he arrived. At about 8.00pm on the evening after he arrived, he stripped the plastic insulation from his kettle lead and plugged it into the electrical socket. He gave no explanation for his actions, but staff were concerned about his intentions and began ACCT procedures.
2. At an assessment interview the next morning, the man said that he would kill himself in the next few days. A mental health nurse reviewed him and decided to admit him to the healthcare unit for a period of assessment.
3. Over the following days, the man made a number of strange comments, including that prison staff had permission to kill him. He then appeared to begin to settle. On 18 December, he told one of Birmingham's psychiatrists that his feelings had been caused by frustration about being in prison, but he had no current thoughts of suicide or self-harm. The psychiatrist considered that he had been suffering from depression and was now in partial remission.
4. That evening, the man became angry and smashed his television set. He said he had toothache and needed to see a dentist immediately. He used a piece of Perspex from the broken television to cut his arm and abdomen. The cuts were noted to be superficial with no bleeding.
5. At about 8.35pm on the evening of 19 December, a nurse checking the man found that he had moved onto the floor behind his bed and was out of sight. He was required to be checked twice an hour and at each check after that the nurse noted that he was unable to see him as he was hidden behind the bed and he did not respond. At around 10.15pm, an officer asked the night manager to come to the healthcare unit as the staff were concerned that they had been unable to see the man and he had not responded when they checked. (Prison staff are not permitted to open cells at night without the presence of a manager, unless it is an emergency.)
6. The night manager arrived about half an hour later. He had not considered the situation with the man as urgent and had first taken a nurse to see a prisoner who had reported chest pain. The night manager and other staff went into his cell. They pulled away a blanket, which he had covered himself with and saw that he had a ligature around his neck, made from a strip of sheeting, which he had attached to his leg, apparently to allow him to tighten it. He was unresponsive. Healthcare staff and paramedics attempted resuscitation but, at 11.20pm, paramedics pronounced him dead.

7. We consider that it would have been difficult for staff at Birmingham to have foreseen the man's actions that evening. However, staff should have informed the night manager as soon as it became apparent that they could not carry out appropriate ACCT checks because he was out of sight and not responding. When the night manager first arrived at his cell, he or other staff should have fully checked the man to establish his wellbeing. The investigation identified a need for improvement in management of the suicide and self-harm procedures and in communicating medical emergencies.

## **THE INVESTIGATION PROCESS**

8. Notices were issued to staff and prisoners at HMP Birmingham, informing them of the investigation and inviting them to contact the investigator if they had relevant information. One prisoner responded.
9. On 2 January 2014, the investigator went to HMP Birmingham, met the Director and the Head of Healthcare and obtained copies of the man's prison and health care records. He subsequently interviewed 17 members of staff and one prisoner.
10. The investigator wrote to the Coroner of Birmingham to inform her of the Ombudsman's investigation and we have sent her a copy of this report.
11. NHS England (Shropshire and Staffordshire Area) appointed a clinical reviewer to review the man's clinical care at HMP Birmingham. The clinical reviewer joined the investigator for interviews with the healthcare staff.
12. One of the Ombudsman's family liaison officers wrote to the man's family, who lived in Eritrea, to inform them of the investigation and invite them to identify issues for the investigation to consider. The letter was returned undelivered and we have been unable to contact them.

## **HMP BIRMINGHAM**

13. HMP Birmingham is a large local prison, principally serving the courts of the West Midlands. It holds a maximum of 1450 remand and sentenced men. Since 1 October 2011, it has been managed by G4S Care and Justice Services. Healthcare services are provided by Birmingham and Solihull Mental Health Foundation Trust. The healthcare centre operates 24 hours a day.

### **Her Majesty's Inspectorate of Prisons**

14. The last inspection of Birmingham was in March 2014. Inspectors noted a high prisoner turnover and movements because of overcrowding meant that prisoners often arrived at reception late, putting first night and induction procedures under great strain. Despite this, inspectors found that first night staff were caring and generally did a good job keeping prisoners safe.
15. The number of incidents of self-harm was not high taking into account the size and complexity of the population. The quality of ACCT documents was found to be generally good, although some night observations were too predictable.
16. Inspectors found that primary, in-reach and forensic mental health services were well integrated.

### **Independent Monitoring Board**

17. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community, who help ensure prisoners are treated fairly and decently. In their annual report for 2012-2013, the Board reported that Birmingham's safer custody team continued to be pro-active, making frequent checks on the quality of ACCT reviews.

### **Previous deaths**

18. The man's death was the tenth of eleven apparently self-inflicted deaths at Birmingham since February 2010. As with the man, two of the previous deaths occurred shortly after the prisoners' arrival at the prison: one within five days and the other within nine days. There were no other significant similarities between the circumstances of those deaths and that of the man.

### **Assessment Care in Custody and Teamwork**

19. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and managing prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held.

## KEY EVENTS

20. The man was born in Eritrea and English was his second language. He had been seeking asylum in the UK. He was remanded to HMP Birmingham on 10 December 2013, charged with wounding with intent to cause grievous bodily harm. He had previously been at Birmingham from 30 October 2012 to 22 May 2013. Between 12 December 2012 and 21 January 2013, he had been managed under ACCT suicide and self-harm prevention procedures after he had become upset following a telephone call to his family in Eritrea and had asked to be sent home. The prison GP had diagnosed reactive depression and prescribed antidepressants. The mental health team assessed the man several times, because of concerns about his presentation and behaviour, but concluded he did not have a mental illness.
21. At a reception health screen on 10 December, the man told a nurse about his previous time in prison a few months earlier and said that he did not mind being back. He said he wanted to go to L wing (a standard prison wing) and she advised him to speak to an officer about this. The nurse noted that the man had no thoughts of suicide or self-harm or mental health problems and that he was not registered with a community GP. The man moved to the first night centre on D wing.
22. At about 8.15pm on 11 December, the electrical circuit on D2 landing failed. Staff discovered that the man had stripped the insulation from his kettle lead and pushed the plug into an electric socket, causing an electrical failure.
23. The first night centre manager told the investigator that the man had given staff no coherent explanation for his actions. He went to see the man, but he was asleep. He then asked a nurse and a doctor, who were working in the unit at the time, to speak to the man as he thought he had been behaving oddly.
24. When interviewed, the doctor said that he was just about to go home when he was asked to see the man. When he arrived, a nurse was already in the cell and the man was lying on his bed hyperventilating (breathing rapidly). He was reasonably calm, but reluctant to give much information. The doctor understood that officers would monitor him through the night. He considered that was sufficient to keep him safe overnight and intended to arrange a full psychiatric assessment the next day. The doctor acknowledged that he had omitted to make an entry in SystemOne, the prison's electronic medical records. He said he would ordinarily have made an entry during his next shift in the prison, but had forgotten to do so on this occasion.
25. The first night centre manager had not thought it necessary to begin ACCT suicide and self-harm prevention procedures but, at the end of his shift, he asked a Prison Custody Officer (PCO) to check the man through the night. When he arrived home, the first night centre manager thought he had been wrong not to open an ACCT document, so he telephoned and asked the PCO to do so. He told the PCO that hourly observations should be sufficient while the man was asleep and in bed, but that if he were to wake and to start moving around his cell, the PCO should use his judgement and set more frequent checks.

26. The PCO opened an ACCT plan just after 10.00pm. He told the investigator that the man had slept through the night so he had kept the observations at one per hour.
27. Another PCO held an ACCT assessment interview with the man at 8.00am on 12 December. (Assessment interviews should explore the prisoner's problems, his current risk of suicide or self-harm, plans for the future and what might be done to reduce his risk.) The man said he did not like being in prison and would kill himself within the next few days. The PCO included in her summary of the key issues that the mental health team should see him.
28. At around 11.00am, a member of the safer custody team took the man to his first ACCT case review. The safer custody team member told the investigator that the first night centre manager decided that the review should be postponed to the afternoon as the man appeared mentally confused and someone from the mental health team should see him first. A mental health nurse went to see the man an hour later. He told her that he wanted to die and that he would be dead within two days. She noted that the man should be admitted to ward 2, the prison's mental health unit, to be observed for 48 hours.
29. At 2.00pm, a first line manager held the man's first ACCT case review. Two PCOs attended but no one from healthcare was present, despite this being a mandatory requirement for first reviews. The first line manager noted that the man appeared very confused and was behaving bizarrely. The man said that he had no thoughts of self-harm. The first line manager told the investigator that he was aware that the man was to be admitted to ward 2 and he was content that hourly observations were sufficient until he moved. The first line manager said that, ideally, someone from the healthcare team should have been present, but in the first night centre the reality was that they were often held only with the staff available at the time. He had been content to proceed without a mental health nurse in his case as the man was going to be admitted to the healthcare unit later that afternoon. The first line manager noted two issues on the man's caremap, both relating to mental health support. He set another review for the next day. The level of risk was not recorded.
30. The man moved to ward 2 that evening and gave no cause for concern overnight. On 13 December, a nurse introduced herself to him as his 'named nurse' and tried to explain plans for his care. She told the investigator that the man would not engage properly and had said in a matter of fact tone that he understood that he had been brought to the ward to be given a lethal injection as he was a criminal. She said that, as a ward 2 in-patient, the man would be reviewed as a matter of routine by the psychiatrist. She considered there was no reason for him to be seen before the next psychiatrist's ward round four days later. In the interim, she noted in the man's records that nurses should encourage him to engage.
31. The ACCT review scheduled for the afternoon of 13 December did not take place. A nurse noted the man's ACCT document that he "... declined to [attend]. Irate when encouraged. Observations to remain the same ... re-attempt review [tomorrow]". However, a review was not held on 14 December

and there was no explanation for this in the man's records. An entry in the man's clinical records at midday noted that his interaction with staff that day had been limited to accepting or declining food and drink and his replies to questions were at times too mumbled to understand. The nurse made a further attempt to engage with the man that evening and noted his records, "... continues to have minimal interaction with staff ... appears to feel threatened when approached ... Presents as paranoid ...". She added that the man had spent time watching television in the communal area, but had not interacted with other prisoners.

32. In the afternoon of 15 December, a nurse chaired an ACCT review, accompanied by a PCO. The man attended and said again that he wanted to die and asked if the staff could "inject him with something lethal". He said that he had made previous attempts on his life, including using a ligature. The nurse noted that the man was low in mood and raised the level of observations to two an hour. She set the next ACCT review for 20 December. She said that the man had made the comments about wanting to die towards the end of the review and until then, he had considered reducing the frequency of observations.
33. Entries in the man's records indicate that he had eaten little since he arrived at Birmingham and had not mixed much with other prisoners. However, on the evening of 15 December staff noted that he had eaten his meal at the dining table with other prisoners and spent some time playing pool, watching television and chatting with others prisoners.
34. Listeners are prisoners trained by the Samaritans to provide confidential support to other prisoners in distress. A Listener at Birmingham told the investigator that he did not know the man but he had noticed he was not eating much, so he had gone to his cell on 16 December to speak to him. The man said he wanted to die and that he was terrified of going to a standard prison wing. The Listener told him that the wings were all right, but if he was worried he could speak to officers about his concerns. The Listener went to see the man again the next day. He said the man looked really down and said again that he wanted to die. The Listener asked his permission to tell staff about his suicidal thoughts, but the man asked him to promise not to say anything. The Listener said he had thought carefully about speaking to an officer before concluding that he would have to abide by the Listeners' rules on honouring confidentiality.
35. The consultant psychiatrist held ward rounds each Tuesday morning and he discussed the man at the ward round on 17 December. He noted the background leading to the man's admission to ward 2 and added:

"... since the evening of [15 December] he has presented as less anxious and paranoid, engaged with peers to play pool and watch television, and verbal interaction has increased. However not yet engaged in 1:1 keyworker sessions [with his named nurse] ..."
36. The man's named nurse said that she had a session with him on the evening of 17 December and spent about 25 minutes going through a standard set of

health and social care questions. He told her that, before his admission to ward 2, he had become extremely emotional about returning to prison. He had found being in custody a struggle and that was why he had spoken about wanting a lethal injection. The named nurse said there had been a marked improvement in the man's presentation since his admission to the ward and he had denied any true intent to take his life. After the consultation, they played a game of pool. When they finished, she encouraged another prisoner to play a game with him.

37. A second psychiatrist assessed the man on the morning of 18 December. The second psychiatrist said that he had particularly wanted to explore his thoughts of suicide and requests for a lethal injection. As he had a limited command of English, the second psychiatrist used a telephone interpretation service. (Other witnesses told the investigator that they thought his English was reasonable so they did not need to use the telephone interpretation service.) He told the psychiatrist that his comments about a lethal injection were more a figure of speech due to his limited English and also a result of his frustration about being in prison. He said that he preferred being in ward 2 as he found the prison wings too noisy. He felt he was improving and said he did not have any suicidal thoughts. The second psychiatrist noted that he appeared to have been suffering from depression that was now in partial remission. He prescribed fluoxetine, an anti-depressant.
38. The man had complained about toothache for several days and at about 8.30pm on 18 December, he asked to see a dentist. The ward 2 nurse told the man that an appointment had been booked for the next day and, in the meantime, he should take the painkillers that had been prescribed. The man then said that he wanted to have a shower and the ward 2 nurse told him that was not possible at that time of day. The man responded by smashing his television and he used a piece of broken plastic to make some superficial lacerations to his arm and abdomen. The ward 2 nurse called officers to remove the broken television and noted in the man's records that the lacerations had caused no bleeding. The ward 2 nurse said that the man calmed down after this and was asleep by 10.30pm. The ACCT observations remained at two an hour.
39. The consultant psychiatrist was on ward 2 in the early afternoon of 19 December when he came across the man, who was trying to complete an application for access to the prisoner telephone system, to allow him to make calls to family and friends. The consultant psychiatrist said that they did not speak much, but he lent him a pen for which he had thanked him and had interacted normally. Because of the previous concerns, the consultant psychiatrist thought he should remain on the ward for a few more weeks to allow for further assessment.
40. The dentist saw the man on the afternoon of 19 December and identified that one of his teeth needed to be extracted. The man asked if he would be sent to hospital for this. When the dentist told him that routine extractions took place in the prison the man became abusive and refused treatment.

41. The ward 2 nurse who was on duty that evening noted in the man's clinical records and ACCT plan when he checked his cell some time after 8.30pm that he could not see him. The ward 2 nurse told the investigator that he thought the man might have been moved to another cell, but he asked an officer to unlock the cell door so they could go in and check. They found the man covered with a blanket, lying on the floor in the gap between the bed and the wall. (Beds in ward 2 comprise a resin plinth about a metre from the wall topped with a mattress.) The ward 2 nurse told the man to get up, but he did not reply. The ward 2 nurse lifted the blanket to get some reaction but the man did nothing except move his leg. As he had previously been aggressive, the ward 2 nurse decided not to do anything more which might provoke him and they left the cell. He thought that the time by then was around 8.50pm.
42. A night PCO came on duty at around 9.00pm. (An officer is always on duty in the healthcare unit and the night PCO was responsible for security on both ward 1 and ward 2.)
43. The ward 2 nurse's next four ACCT entries for the man stated:
  - "[9.00pm] Remains behind the bed, difficult to observe."
  - "[9.35pm] Behind the bed, movement not noted." (The 'not' was added at the time of the next entry when the nurse realised this was an error.)
  - "[10.00pm] Behind the bed."
  - "[10.30pm] Behind the bed. No response. Oscar 1 informed." (Oscar 1 is the radio signal for the manager responsible for the operation of the prison.)
44. The ward 2 nurse said that he had been very busy that evening because there had been four prisoners on ACCTs plans, one of whom had to be observed four times an hour and had been difficult to manage. He had also dealt with several requests from other prisoners, including a prisoner complaining about abdominal pain. He said that each time he checked on the man he called to him and knocked on his door but got no response. When he failed to get a response from him at the 10.00pm check, he told the officer that he needed the night manager and the emergency response nurse to help with him and for a second opinion on the prisoner in pain.
45. The night PCO told the investigator that he telephoned the night manager and the emergency response nurse to tell them that they were needed on ward 2. The emergency response nurse said that he had two or three incidents to deal with first and would go to ward 2 with the night manager as soon as possible. The night manager told the investigator that he had received two telephone calls at around 10.15pm. One was from the night PCO asking him to come to see the man in ward 2 and the other was from the emergency response nurse about a prisoner in pain. Neither report seemed particularly urgent so, before going to ward 2, the night manager first took the emergency response nurse to one of the wings to see a prisoner with chest pain.
46. The night manager then went to ward 2 with the emergency response nurse and another PCO. When they arrived, the emergency response nurse went to speak to the prisoner in pain while he went to the man's cell. He tried to

persuade the man to move on to his bed so he could be seen. As he did not respond, the night manager unlocked the cell at 10.43pm and went in. The man was lying on the floor in a foetal position, covered with a blanket. The night manager thought that he saw movement in the man's shoulder, but he then had to leave the cell as another prisoner began to scream and the staff needed to open that prisoner's cell. The prison's night security practices did not ordinarily allow two cells to be open at the same time.

47. The staff quickly established that there was nothing seriously wrong with the other prisoner and the night manager and the other staff went back to the man's cell to try to persuade him to move to a visible position on his bed. When they went into the cell, the ward 2 nurse pulled the blanket off him and saw that he had a noose tied around his neck, with the end looped around his ankles and did not respond.
48. The night manager did not see the man but the ward 2 nurse told him that they needed an ambulance immediately. He therefore ran out to the corridor, radioed the communications room to say that an ambulance was needed urgently. He said that he realised he should have used the term 'code blue' in the radio call but felt that there would have been no doubt from the tone of his voice that it was an emergency. He then went to his office and gave the communications room further details to pass to the ambulance service. (He called the communications room at 10.56pm and the call to the ambulance service was logged at the same time.)
49. Both nurses cut the noose from the man's neck and, with the help of the officers, lifted him onto the bed. After checking for a pulse and signs of breathing, the nurses began to try to resuscitate the man. They explained that they had placed him on the bed as there was not enough room to attempt resuscitation on the floor and, as the bed comprised a thin mattress on a solid plinth, it was a suitably firm surface for giving chest compressions. The nurses gave oxygen in between chest compressions and used a defibrillator which did not advise a shock. Paramedics arrived at 11.02pm. When they examined the man they found that the noose had crushed his larynx (wind pipe). They continued to attempt resuscitation until 11.20pm, when they pronounced him dead.
50. Checks were made on all of the other prisoners in healthcare and all prisoners on open ACCTs.
51. The man had named his sister in Scotland as next-of-kin, but had not given her address. He had also listed other family contacts in Eritrea on his telephone application. The prison contacted his family by telephone to break the news. Subsequently they reimbursed the costs of repatriating the man's body to Eritrea.

## ISSUES

### Clinical care

52. The clinical reviewer concluded that the care the man received for his mental health problems was better than he could have expected outside prison. He noted that, by 19 December, the man appeared to be getting better and he did not consider that there were any signs that his actions that day could have been foreseen or prevented.
53. However, the clinical reviewer was critical of healthcare record keeping, such as the custom of entering summary notes for patients at the end of the day, rather than keeping contemporaneous records in line with Nursing and Midwifery Council guidance. The Healthcare Manager will need to address these issues contained in the clinical review.

### Management of the suicide and self-harm prevention procedures

#### *Assessment of risk of suicide and self-harm at reception*

54. The man had been released from Birmingham on 22 May 2013. During his seven months in prison, mental health staff had assessed him several times after staff reported concerns about his presentation. The GP had diagnosed depression and for six weeks the man had been managed under ACCT suicide and self-harm prevention procedures. When he returned to Birmingham on 10 December 2013, the reception nurse recorded that the man had no history, or current thoughts of self-harm.
55. It seems that, in assessing the man's risk of suicide or self-harm, the reception nurse and officers relied heavily on his statement that he had no such thoughts at that time. They do not appear to have been aware that he had previously been managed under ACCT procedures at Birmingham. We would have expected this to have been noted and it is not clear what weight reception staff placed on other factors. However, the man had no previous history of self-harm and had not been diagnosed with depression or any other mental illness at the time he arrived at Birmingham in December and we accept that it is unlikely that he would have been assessed as a risk of suicide and self-harm even if his history had been taken into account.

#### *Opening ACCT procedures*

56. On the evening of 11 December, the man stripped the plastic insulation from the lead of his kettle and plugged the lead into the electric socket. When the first night centre manager went to speak to him, he found him in asleep in bed. He asked a doctor and a nurse to see him. At that point, the first night centre manager did not consider it necessary to start the ACCT process, although he asked a PCO to check him through the night. Shortly afterwards, the first night centre manager finished his shift. After getting home, he reflected on his earlier decision and telephoned the PCO to instruct him to open an ACCT plan. We consider that starting the ACCT procedures was the correct decision and the short delay in doing so did not impact adversely on the man's welfare.

### *ACCT case reviews and observations*

57. It is a mandatory requirement of ACCT procedures that first case reviews should be multidisciplinary and include healthcare representation. After that they should be multidisciplinary where possible and appropriate specialists involved in the care of the prisoner, such as mental health staff, should attend. It was noted at an early stage that the man's behaviour had given staff cause for concern about his mental well-being. His first ACCT case review on 12 December was not multidisciplinary, as required by Prison Service Instruction 64/201 and took place without a mental health representative.
58. The investigation identified several other omissions in ACCT processes:
- The man had two ACCT case reviews and both times his assessed level of risk was not indicated on the ACCT record.
  - When the man refused to attend an ACCT case review on 13 December, the review was postponed and an entry was made in his ACCT record to try again the next day. A review was not held the next day and no explanation was given. Although it is best practice for prisoners to attend their ACCT case reviews, it is permissible for reviews to take place without their input.
  - The majority of the man's night-time ACCT checks were recorded at precise hourly or half hourly intervals, contrary to national instructions which expects them to be at random times so the prisoners cannot predict the times.
  - Staff did not consider whether the man's risk had increased after he smashed his television and deliberately cut himself with some of the fragments.
  - At night, nurses working on the inpatient wards are required to press cell bells (which is then recorded) to confirm that they have made ACCT checks. The ward 2 nurse did not always comply with this requirement.
  - The ward 2 nurse told the investigator that he had not received ACCT training, but had instead learned from colleagues.

In view of the weaknesses identified, we make the following recommendation:

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

- **Ensuring that all staff receive training about the ACCT procedures;**
- **Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner's care; where this is not possible advice should be sought and documented as part of the review;**
- **Completing ACCT documents fully and accurately, including following the prescribed level of observations at irregular intervals;**
- **Conducting an ACCT review whenever there is a clear sign that risk has increased.**

### *ACCT checks on the evening of 19 December*

59. The last time staff observed the man apparently alive was some time between 8.35pm to 8.50pm. He was lying behind his bed at that time, but he was out of sight and did not respond when the ward 2 nurse attempted to observe him several times after that. The fact that he was not visible to staff was not in itself an emergency, but it is important that prisoners assessed as at risk of suicide and self-harm are observed at each check to be alive and not harming themselves. Staff should have informed the night manager about the problem sooner so that they could go into the cell and check him.
60. The night manager went to ward 2 after staff reported difficulties with two prisoners and neither could be unlocked without him. While the emergency response nurse went to speak to the other prisoner, the night manager went into the man's cell at about 10.43pm to try to persuade him to move onto his bed so staff could observe him. The man was covered by a blanket, but the night manager believed he saw his shoulder move. At that point, the other prisoner started to scream. The night manager decided that he was the more urgent problem at that stage, so he left the man and relocked his cell. After they had dealt with the other prisoner, the night manager returned to the man at around 11.00pm, when he was discovered with a noose around his neck.
61. We cannot know for certain whether the man was still alive the first time the night manager went into his cell and thought he had observed some movement. When the other prisoner began to scream in pain, he decided that he needed to attend to that prisoner immediately. However, by that time, two hours had elapsed since the man had last been observed to be alive, yet he was required to be observed at least twice every hour. We consider that before leaving the cell, the night manager should at least have established that the man was alive, was not unwell and did not need urgent medical attention. It would only have taken seconds to have pulled the blanket back from him to observe him properly. We make the following recommendation:

**The Director should ensure that staff take immediate action if a prisoner is not visible or does not respond during ACCT observations and that staff conducting checks fully establish that the prisoner is alive and well and does not need urgent medical attention.**

### **The emergency response**

62. Prison Service Instruction (PSI) 3/2013 *Medical Emergency Response Codes*, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called. It also explicitly states that all prison

staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.

63. When the ward 2 nurse removed the man's blanket and discovered the ligature, he asked the other staff to call an ambulance. The night manager said that he did not know what the problem was, but radioed the communications room to ask for an ambulance. He did not use an emergency response code. Prison records show that, in spite of this, staff in the communications room called an ambulance immediately and it arrived within six minutes. We are surprised that, as the night manager, he did not establish what had happened to the man and exactly why the ambulance was required.
64. We are satisfied that there was no delay in calling an ambulance and in this case no detrimental effect in not using an emergency medical code as the man was located in the healthcare centre where nurses and emergency equipment were immediately to hand. However, in other cases the failure to use an emergency code correctly could affect the chances of a prisoner's survival in an emergency. We make the following recommendation:

**The Director should ensure that, in line with PSI 03/2013, all staff fully understand and follow the protocol for emergency medical codes.**

#### **The design of the healthcare cells**

65. The beds in ward 2 comprised a solid plinth set around a metre from the outside wall, leaving a gap between the bed and outside wall where a prisoner could lie out of sight from the cell door observation panel. We were concerned that this design compromised the safety of prisoners. However, since the man's death, funding has been agreed to reposition the beds so that they abut the wall and eliminate the blind spot. We understand that work has now started to make this modification so we make no recommendation.

## RECOMMENDATIONS

1. The Director and Healthcare Manager should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Ensuring that all staff receive training about the ACCT procedures;
  - Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner's care; where this is not possible advice should be sought and documented as part of the review;
  - Completing ACCT documents fully and accurately, including following the prescribed level of observations at irregular intervals;
  - Conducting an ACCT review whenever there is a clear sign that risk has increased.
2. The Director should ensure that staff take immediate action if a prisoner is not visible or does not respond during ACCT observations and that staff conducting checks fully establish that the prisoner is alive and well and does not need urgent medical attention.
3. The Director should ensure that, in line with PSI 03/2013, all staff fully understand and follow the protocol for emergency medical codes.

## Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Director and Healthcare Manager should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> <li>• Ensuring that all staff receive training about the ACCT procedures;</li> <li>• Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner’s care; where this is not possible advice should be sought and documented as part of the review;</li> <li>• Completing ACCT documents fully and accurately, including following the prescribed level of observations at irregular intervals;</li> <li>• Conducting an ACCT review whenever there is a clear sign that risk has increased.</li> </ul>	Accepted	<p>All new staff who have prisoner contact will undertake the "Introduction to Safer Custody" course as part of the staff induction programme. This course includes ACCT awareness training.</p> <p>The establishment has an on-going programme of refresher training in ACCT awareness. ACCT case management and ACCT assessor training are also made available where necessary.</p> <p>All ACCT case reviews are aimed to be multidisciplinary. Where relevant staff are not able to attend, they are invited to make a written contribution.</p> <p>All staff are made aware through ACCT training and published Operational orders of the need to record levels of observations within the ACCT document and that observations should be at irregular intervals.</p> <p>All staff have been informed through ACCT Training and a published Operational Order of the need to conduct an immediate case review whenever a clear sign of increased risk becomes apparent. Compliance with this</p>	Completed and ongoing	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			requirement will be monitored through a process of a Safer Custody Department weekly ACCT Quality Assurance report and the daily Residential First Line Manager and Senior Management checks		
2	The Director should ensure that staff take immediate action if a prisoner is not visible or does not respond during ACCT observations and that staff conducting checks fully establish that the prisoner is alive and well and does not need urgent medical attention.		Staff have been informed through the publication of an Operational Order of what immediate actions are required in the event that they aren't able to see or gain a response from a prison on an open ACCT document.	Completed – August 2014	
3	The Director should ensure that, in line with PSI 03/2013, all staff fully understand and follow the protocol for emergency medical codes.		All staff have been informed through the publication of an Operational Order of actions to take in response to a medical emergency to include the use of a code Red/Blue radio transmission	Completed – August 2014	