

**Investigation into the circumstances surrounding the  
death of a man  
at HMP Risley in April 2011**

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

**June 2013**

This is the report of an investigation into the death of a man, who was found hanging from the light fitting in his cell at HMP Risley in April 2011. He was 31 years old. I extend my condolences to the man's family.

One of my investigators carried out the investigation. Warrington Primary Care Trust commissioned a clinical reviewer to carry out a review of the man's clinical care in prison. I apologise that this report has been delayed so long.

The man had previously attempted to harm himself in prison, but when he arrived at Risley, in February 2009, he was assessed as a low risk of self-harm and suicide. In his first year at Risley, there were no concerns about his mental health. In February 2010, he took an overdose of medication and suicide and self-harm monitoring procedures were put in place. On seven other occasions, he either harmed himself or displayed behaviour that led staff to believe he was at heightened risk to himself. Prison staff held frequent reviews about his risk, many of which appear to have involved staff from the mental health team, but he did not always engage fully. At the time of the man's death, he had been assessed as at low risk of self-harm, but because he was recognised to be unpredictable in his actions, and because he felt protected by the arrangements, it was decided to continue monitoring him until his release, which was due on 22 June 2011.

It is of concern that the prison was unable to find most of the man's suicide and self-harm monitoring documents. From those available, and other source records, it appears that monitoring was started appropriately, but not all the case reviews were multidisciplinary and some actions in the care and management plans were incomplete. The man said he had threaded sheets through light fittings on several occasions and, while it is impossible to make all cells free of ligature points, another prisoner at Risley recently hanged himself, apparently in the same manner. I therefore recommend that the light fittings are assessed to see if any modification is feasible to make them safer.

The man was frequently regarded as a risk of suicide and self-harm during his time at Risley and I am satisfied that he received appropriate mental health input and support from a range of staff. In the period leading up to his death, he seemed more positive and looking forward to the future. While some degree of risk was always apparent, I do not consider that staff could reasonably have predicted or prevented his death that night.

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**

**June 2013**

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## SUMMARY

1. The man was recalled to prison on 29 July 2008, after committing further offences while on licence and transferred to HMP Risley on 5 February 2009. At his initial healthcare assessment, he said he had previous attempted self-harm in prison but had no current thoughts of doing so.
2. A year later, in February 2010, the man took an overdose of tablets. He subsequently made several further attempts at self-harm and was formally monitored under ACCT procedures. (Assessment, Care in Custody and Teamwork – the Prison Service system for monitoring those at risk of suicide and self-harm.) ACCT case reviews were held to monitor his behaviour and support him but the man would not always engage with the process. We found that ACCT reviews were not always multidisciplinary and some careplan objectives were sparse and incomplete.
3. The man was also frequently assessed by the mental health team in the prison, although he was not always willing to engage with them. A psychiatrist concluded that he had no treatable mental health illness. He was prescribed citalopram (an antidepressant) but took this irregularly. The community psychiatric nurse in the prison thought the man might have a personality disorder and referred him to a secure mental health facility for an assessment but he did not meet the hospital's criteria.
4. Suicide and self-harm monitoring procedures were in place at the time of the man's death. Although his behaviour had improved and his risk of self-harm and suicide was assessed as low, prison staff agreed it would be beneficial for him to remain subject to monitoring until his release date on 22 June 2011.
5. The man was discovered hanging in his cell from a light fitting at 12.20am on a morning in April, emergency assistance was requested and an ambulance called. Healthcare staff and paramedics attempted to resuscitate him, but paramedics pronounced him dead at 1.17am.
6. We make five recommendations relating to the suicide and self-harm prevention process, entering cells at night, inspecting light fittings and debrief meetings. Although some shortcomings were found, we do not believe that staff could have prevented the man's death on that night.

## THE INVESTIGATION PROCESS

7. Notices about the investigation and terms of reference were sent to the prison, inviting staff or prisoners with any relevant information to contact the investigator. Three prisoners came forward.
8. The investigator visited HMP Risley on 6 May 2011. He met the deputy governor and other senior managers, as well as staff from the chaplaincy and healthcare departments. He received copies of the documents relating to the man's time in custody. The prison was unable to find some of the suicide and self-harm monitoring documents.
9. The investigator returned to Risley on 10 and 11 October, to conduct interviews with staff and prisoners. One of the prisoners who had contacted the investigator was released before he could interview him and could not be found through the probation service. Regrettably, the notes of interviews with the other prisoners have been mislaid but statements taken at the time by the prison are available. .
10. A clinical review of the man's medical care was commissioned by Warrington (PCT) and undertaken by a clinical reviewer.
11. The investigator informed HM Coroner for Cheshire about the investigation, who has been sent a copy of this report.
12. One of our family liaison officers informed the man's family of the investigation. They had the following concerns which they wished the investigation to take into account:
  - When the man's parents saw him after his death, he had a beard and had lost weight. They said that in a previous prison, he had become withdrawn, isolated and depressed, and had grown a beard. The beard was a warning signal to them and they wanted to know whether staff at Risley had noticed these changes, which would have indicated his vulnerability.
  - They would like consideration given to cells being designed to make suicide or self-harm as difficult as possible and free from ligature points.
  - The prison's family liaison officer visited the family after the man's death and explained that they had been looking into his psychiatric care. His parents would like to know more about this.
13. We regret the delay in issuing this report, caused by a backlog of cases which we are striving to clear and compounded by staffing changes during the course of the investigation.
14. The man's family received a copy of the draft version of this report as part of the consultation period. Having considered the investigation findings his family remained concerned about the issues of his medication and assessment

processes. However they felt that staff had done as much as they could within their capacity. The investigator has reviewed the findings of the investigation and made changes where necessary to the report.

## **HMP RISLEY**

15. HMP Risley is a category C training prison in Warrington, Cheshire, which holds up to 1095 prisoners. It has seven wings and a segregation unit. The man lived on Ravensmoor (R1) wing, which houses vulnerable prisoners in single cells.
16. Risley has 24-hour healthcare, provided by Warrington Primary Care Trust (PCT). During the day, there is a doctor available in the prison and nurses provide healthcare cover at night. Prisoners who need inpatient treatment are transferred either to other prisons or to hospital.

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

17. The most recent inspection at Risley was a full, announced inspection conducted in February 2011. The Chief Inspector of Prisons found the prison "transformed in many areas" since the previous inspection in 2008. He noted in his introduction to the report:

"There is still much to be done to ensure that the prison becomes a fully effective establishment that meets the range of prisoners' diverse needs and prepares them appropriately for release through useful work and effective interventions. Nevertheless, Risley is a much safer, cleaner and more decent prison than before - a better and more purposeful place for prisoners (and as they often told us, a better place for the prison staff to work). The Governor and the prison staff are to be commended on the improvements."

In relation to self-harm, inspectors said:

"Good investigations into incidents of self-harm helped identify areas for improvement ... the investigating process itself was a cathartic exercise for prisoners, who were asked about their feelings as well as the facts. Learning and action points were established and copies of investigation reports sent to relevant departments".

## **Independent Monitoring Board**

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who monitor standards to help ensure prisoners are treated fairly and decently. In the last published IMB report for the year to March 2012, the Board were concerned about the management of prisoners with serious mental health problems. They were satisfied with the processes for managing at-risk prisoners. The report lists only one death at Risley during the period covered by their report, although our records indicate that there were four – two self-inflicted and two from natural causes.

### **Previous deaths in custody at Risley**

19. Fifteen prisoners have died at Risley since the Ombudsman became responsible for investigating deaths in custody in 2004, five of them after this man. In the most recent death, the prisoner also [appears to have hanged himself from a cell light fitting](#).

### **Suicide and self-harm monitoring**

20. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of 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 monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

## KEY EVENTS

21. The man was released from prison on 11 July 2008. He had served several previous sentences, mostly for crimes to gain money to fund his drug use. He was recalled to prison on 29 July 2008, for breaching his licence conditions after committing two assaults. On 5 February 2009, he transferred from HMP Preston to HMP Risley.
22. When the man arrived at Risley, a nurse carried out a healthcare screening assessment. He told her that he had tried to harm himself in prison 13 months before but had no current thoughts of self-harm. She noted previous prescriptions for medication (citalopram, an anti-depressant, and olanzapine, an anti-psychotic) for mental health conditions, but he was not presently taking any. His weight was 68kg.
23. The nurse referred the man to the doctor as he had been diagnosed with hepatitis C and because of his previous mental health problems. He declined to see a community psychiatric nurse and said he would tell healthcare staff if he needed to see one in the future.
24. A Cell Sharing Risk Assessment was completed on 27 February. It was noted that the man had a history of self-harm, and he was assessed as a high risk of harming a cellmate. (His risk continued to be assessed as high throughout his time at Risley.)
25. The clinical reviewer in his review notes that the man was seen numerous times to discuss treatment for hepatitis C. A year's treatment, supervised by a hospital consultant, began on 13 November. He was given interferon, which he administered himself. (The dosage was subsequently reduced owing to a low blood count. One of the prison's psychiatric nurses later noted that one of the side effects of the drug is suicidal ideation.) He saw a nurse on 11 December. His weight was 69kg. He said that he was coping well with the interferon, and she recorded that his mood was fine.

## 2010

26. On 14 February 2010, the man was found to have put his mattress against the cell door and smashed the television and toilet. Later that day, he said he had taken an overdose of 50 tablets, including ribavarin (a drug used in the treatment of hepatitis C), cetirizine (an antihistamine) and paracetamol. After medical advice and a blood test, he was admitted to hospital and treated for paracetamol poisoning. It was noted in the medical record that an Assessment, Care in Custody and Teamwork (ACCT) plan was opened. (The ACCT document is missing, so the information we have is taken from a summary in his medical record.)
27. The hospital discharged the man on 17 February. When he returned to the prison, a nurse examined him and noted he appeared quiet with poor eye contact, introverted and offered minimal conversation. One of the hospital doctors told the nurse that if the man lived alone in the community, he would

have been happy to discharge him. Nevertheless, he was placed under constant supervision in a gated cell on D wing, as the discharging doctor at hospital thought he might still want to harm himself.

28. Later that day, the man was assessed by a community psychiatric nurse (CPN) who noted on his medical record that he attended the ACCT review meeting and that he:

“...engaged in the review process and gave an account of events leading up to the self-harm. He suffered with depression before and he has been having side effects to his [hepatitis C] treatment. I believe one of the side effects is suicidal ideation. Things got on top of him and he took the medication but then realised the damage it could do”.
29. On 18 February, a psychiatrist assessed the man who told her that he was bored at work and was having problems with the side effects of his medication. He said he felt guilty about how he had treated his family and that people would be better off without him. He added that he was still having thoughts of taking another overdose and was ambivalent about not succeeding in killing himself. He was prescribed citalopram and a review was arranged for two weeks later.
30. The community psychiatric nurse (CPN) later briefed an ACCT review about the psychiatrist's assessment. The man asked staff not to tell his parents about the overdose. A further review took place on 19 February. He told staff that he felt better and was considering telephoning his parents. He agreed to consider one-to-one counselling with a mental health worker, and to discuss contacting his family. He remained under constant supervision.
31. Prison staff held frequent and regular ACCT reviews from February until 20 April, when the ACCT monitoring ended. Observations were decreased from constant to intermittent on 4 March, on the understanding that the man would tell them if he felt low. At ACCT reviews, he discussed his offences and his relationship with his family. The community psychiatric nurse (CPN) attended each review, and reported that the man remained private and guarded, “which made it difficult to judge what is really going on with him”. He told staff that he did not want to be monitored under the ACCT procedures.
32. Psychiatric assessments at this time indicated there was no evidence of psychosis. The man told the CPN and psychiatrist that he was looking forward to going home and hoped to make a new start, avoiding drugs and getting into trouble. They noted that he appeared low but not hopeless and not actively suicidal. Twice in March and April, he refused further input from the mental health services and his mental health nurse discharged him from her caseload.
33. On 22 April, two days after the ACCT monitoring stopped, a prison doctor noted that the man had not been taking his antidepressant (citalopram) since 13 March. He told the doctor that he felt well and had no thoughts of harming

himself, and the doctor recorded that he appeared stable in mood with no obvious signs of depression.

34. On 10 May, the man told staff he had taken an overdose of a mixture of approximately 40 tablets, including paracetamol, co-codamol and ibuprofen (all pain killers). He was admitted to hospital and discharged two days later.
35. It was noted in his offender management log that an ACCT plan was started after this incident. There is no evidence of this ACCT document in the man's records and the subsequent information is drawn from his clinical record. A mental health nurse noted that she attended a review of his constant supervision on 12 May, in which the man said that he felt a little better and had no thoughts of self-harm.
36. The next day, the mental health nurse assessed the man and noted in his medical records "[He] doesn't feel able to tolerate stress", and "discussed how his suicide attempts have mostly been in prison and that he used substances in the community". He told her, "he did not know whether he would inform anyone if he had suicidal thoughts again" and "that he would have taken more tablets if he had been able to get hold of them". He described his overdose as impulsive and said that he had only had thoughts about it that day.
37. The community psychiatric nurse (CPN) noted in the medical record that he went to the wing twice on 14 May for an ACCT review but on both occasions, they were postponed. When he called again at 3.50pm, a senior officer said that he had already completed the review and had reduced the observations. After speaking to the orderly officer (who manages the operational running of prison during the day), the CPN reiterated to the senior officer that the man was at risk of impulsive self-harm and that a CPN should attend every review.
38. According to the man's medical records, the community psychiatric nurse (CPN) attended a review on 17 May, at which he reminded the senior officer that ACCT reviews should be multi-disciplinary. At a review on 21 May, a mental health nurse noted that the man felt there would always be a risk of him harming himself and that he did not need to be monitored under the ACCT procedures. When she challenged his account of his self-harm history, he became aggressive and walked out of the review. ACCT observations were increased.
39. On 27 May, a mental health nurse went to the wing for an ACCT review, but was told that there was no one available to conduct the review. At the review on 1 June, the community psychiatric nurse (CPN) noted that the man looked unkempt and his cell smelt. He had given his television back, stopped going to gym and seemed to be more isolated. He said that he did not want to see anyone from specialist services. A further review was arranged for 8 June. However, there is no evidence that this review took place.
40. On 14 June, a nurse noted in the medical record that wing staff had told her that the man had given away most of his belongings and clothes. When interviewed by the clinical reviewer, the community psychiatric nurse (CPN)

said the man did not have many possessions in his cell as he was a Jehovah's Witness and that a non-materialistic outlook was his way of following his religion. The nurse noted that the suicide prevention measures were put in place and an ACCT plan was opened. This ACCT document is missing and it is unclear whether the previous ACCT had been closed.

41. Further ACCT reviews took place. On 21 June, the community psychiatric nurse (CPN) noted that the man appeared fairly relaxed and wanted to rebuild his relationship with his family. He asked for his television to be returned, but then gave it back again. He thought that the man had lost weight and suggested he had it checked. The next day, his weight was recorded as 64kg.
42. On 27 June, a nurse was called to B wing. The man had tied an electric cable around his light fitting and was standing on a chair. He alerted a member of staff and told them that he was seeing if the light fitting would hold if he tried to hang himself. He said he was very low and had constant thoughts of suicide. Staff placed him under constant supervision.
43. An ACCT review took place the following day. A mental health nurse noted in his medical record that the man said that he had periods where he was all right followed by a sudden dip in his mood and wanting to end his life. He also said that he did not want to take any medication and found it hard to talk to people. He had sent flowers to his mother in the hope that he would have some form of contact from her. The next day on 29 June, he said he had held a plastic knife to his stomach the previous evening to see if he could cause himself any injury that would end his life. He remained constantly supervised.
44. On 30 June, the man told the community psychiatric nurse (CPN) he had taken nine paracetamol tablets the previous evening while in the shower, which he had obtained from fellow prisoners during association. He told the nurse that every so often a mood came on him which made him think that life was not worth living anymore. He was kept under constant supervision. At the ACCT review on 1 July, a nurse noted that the man had been to the gym for an hour, as well as the chapel and that "[he] can't give any rationale why he keeps self-harming". The psychology team thought that he might be showing signs of a borderline personality disorder.
45. At an ACCT review on 5 July, the community psychiatric nurse (CPN) told the man he had been in contact with a secure NHS mental health facility where the man had been referred during a previous sentence at HMP Preston, to see whether he could be assessed for personality disorder. (A subsequent referral to the facility was declined, as he did not meet their criteria.) Staff from the psychology department at the review noted that the man "lacked insight into his problems". At that review, he said that another prisoner had approached him to discuss how many pills he would need to go to hospital. This gave him thoughts of self-harm. He said he asked the prisoner for a blade but then threw it down the sink.

46. Three days later, on 8 July, a nurse was called to the man's cell after a report of deliberate self-harm. He had two small lacerations on his arms, one was quite deep. She cleansed and dressed the wounds. An ACCT review took place the following day and he engaged well. At that time he was on intermittent observations with a review set for 12 July. (There is no note of this review in the medical record.)
47. A psychiatrist assessed the man on 27 July. He engaged well in the review, and his mood was good. It was suggested that he resume taking citalopram, but he rejected this and told the psychiatrist that he did not like taking medication.
48. On 2 August, a nurse saw the man because staff were concerned that he intended to harm himself, after he had instructed reception staff to destroy his stored belongings. He told the nurse that his things were old and that he did not want any of them when he was released. He complained of feelings of agitation, and had been holding his head and scratching his forehead with his finger nails. The nurse noted that he had "no other feelings of self-harm of suicidal ideation". She encouraged him to go to work and get out of his cell. An ACCT review was completed that afternoon.
49. The community psychiatric nurse (CPN) attended an ACCT review on 16 August, and noted that the man engaged well and seemed less guarded than before. He had his television in his cell again, and agreed to consider speaking to the doctor about medication again. He also talked about his mood swings and his feelings of frustration. At the next review on 23 August, the CPN noted that he appeared calm and engaged well and was adamant he had no suicidal ideation. He noted that he seemed "adamant to change his ways and to prove this to his family". The review team decided to end the ACCT monitoring and a post-closure review was held a week later on 31 August.
50. On 15 November, the man asked to see his offender supervisor about his parole application. As he was not at work that day, another member of the Offender Management Unit contacted the Parole Board, but was unable to get an indication of how long it would take for a decision to be made about his release. As well as telling the man, she also passed this information to his personal officer in case the news increased his anxiety.
51. At 5.00am, on 16 November, an officer told a nurse that the man had been monitored under the ACCT procedures overnight after he told an officer he had taken some tablets. This ACCT document is also missing. The community psychiatric nurse (CPN) recorded in his medical record that an ACCT review had taken place at 4.39 pm and the man said that he wished to move wings. He said he had no intention of harming himself and talked of the future and what he would like to do. The CPN noted that the man should not be allowed to keep drugs in his cell.
52. An entry in the staff observation book on 27 November, noted the man had moved to another unit as he had damaged his cell. He said he had problems

on B wing, which had led to him cause the damage. The community psychiatric nurse (CPN) noted in the past he had isolated himself but had recently been wandering around the wing. The man had also said that other prisoners were trying to get him to “take the wrong road”.

53. On 6 December, the man told staff he had ripped up a sheet the night before and was looking at the light fitting with thoughts of hanging himself. An ACCT review was held immediately, at which he said that he felt uncomfortable and maybe he deserved to die. He said that he had not gone through with killing himself because he had thought of his parents. The community psychiatric nurse (CPN) noted the man “seemed to be wrestling with remorse especially about the assault on his parents”. He was placed on constant supervision. At a review a few days later, he said he was depressed and had ripped the sheets to try and snap himself out of it.
54. The level of observations was reduced in subsequent reviews in December, as the man was thought to be functioning well and socialising with others. He reported no further suicidal thoughts and agreed to work with the psychology department. On 23 December, his offender supervisor checked the progress of the man’s parole application and was told that a decision would not be made until February 2011, at the earliest.
55. On 30 December, a consultant psychiatrist saw the man at his request. It was noted in the medical record that he felt all right in mood and was positive about his future. He agreed to see her again.

## **2011**

56. At an ACCT review on 4 January 2011, the community psychiatric nurse (CPN) recorded that the man seemed relaxed, and motivated to engage with the consultant psychiatrist. Staff at the review meeting agreed to end the ACCT monitoring. Although planned for the following week, there is no record of a post-closure review.
57. On 14 January 2011, the consultant psychiatrist assessed the man for risk behaviours. She noted that he met the criteria for opioid dependence syndrome (in which the desire to take an opiate drug is overwhelming). She advised him to contact the GP if he needed further support and gave him some ideas on how to reduce the level of his risk. The clinical reviewer interviewed the consultant psychiatrist and she told him that the man did not have a discrete and treatable mental illness.
58. Two days later, on 16 January, it was noted that the man appeared to be coping better and had a prison job. He attended the healthcare centre daily and spent more time with other prisoners.
59. An ACCT review took place on 19 January. It is not clear whether a new ACCT had been opened or the previous ACCT re-opened as part of the post-closure process, but the community psychiatric nurse (CPN) refers to an “ACCT Assessor” which suggests it was a new ACCT. The CPN noted in his

record of the review that the man had recently had suicidal thoughts, and was quite vague in his answers. He said that he did not want to hurt himself but was bored. The CPN suggested that he start to plan for his release, including possibly wearing his own clothes. The review meeting set the level of observations as hourly.

60. The man continued to have regular ACCT reviews. On 26 January, the community psychiatric nurse (CPN) noted that the man was on E wing and appeared to have settled in well. He also noted the man had discussed his plans for release and was hoping to get a positive parole decision. The level of observations was reduced.
61. A further ACCT review was held on 31 January. The man said he had no thoughts of self-harm and he continued to work full time. He was also due to undertake one-to-one sessions with the psychologist, and said that he would cope if his parole application failed as he was due for release in June. The review panel agreed to close the ACCT and a post-closure review was planned for a week later. It is not clear if the review took place.
62. On 11 February, the man received a letter from the Parole Board informing him that his parole application had been turned down because his risk of serious harm remained high. On 16 February, the community psychiatric nurse (CPN) saw the man on his wing with his offender supervisor and discussed the refusal of parole. He was disappointed but he did not appear to be upset or make any threats of self-harm. He had stopped taking his medication as he felt that he did not need it and said he no longer wanted to see anyone from the psychology department.
63. On 21 March at 10.00am, the man told an officer that he had tried to tie a sock through his light fitting the previous night, as he was feeling suicidal. The officer opened an ACCT document and wrote on the "Concern and Keep Safe Form", that the man was trying to see if the light fitting would take his weight. This ACCT document was available to the investigator.
64. The man was assessed by an officer at 1.30pm who noted that, although he had tried to kill himself several times, thoughts of his mother and family had stopped him. He said that he currently did not have any thoughts of killing himself, and was looking forward to his release and getting his own place. He then immediately said that he had only ever lived with his mother, which was no longer possible.
65. A senior officer held an ACCT review that afternoon, with the man and a member of the chaplaincy. He appeared calm and said the thought of hanging himself had just come into his head. Observations were set at hourly in the day, and twice an hour at night. The only entry on the caremap was an action to ask one of the doctors to clarify the contents of a hospital letter. There is no record as to whether this action was completed. In spite of the high level of observations, the ACCT monitoring ended just two days later, on 23 March, as he was believed to be relaxed and in good spirits and said he had no further thoughts of harming himself.

66. The post-closure review was held on 30 March, chaired by the senior officer. The man was very positive and said that his sentence had changed his view on life in general. He was looking forward to his release in June and hoped to continue to work with his offender supervisor about his accommodation options and employment on release. He said he had no suicidal feelings and was motivated to achieve things.
67. Three days later, on 2 April at 8.50pm, the man rang his cell bell. An officer went to the cell and the man told him that he felt suicidal. He had turned his bed upside down and torn his bed sheets. The officer started the ACCT process and informed the night orderly officer of the situation. The night orderly officer spoke to the man and offered to organise a phone call to the Samaritans as well as the opportunity to talk to a Listener. He declined both offers. He was also seen by a nurse, who noted that various items including sheets, razor blades and cables had been removed from his cell. He told her that he was not planning to make any further attempts to harm himself. The night orderly officer decided that there should be intermittent observations on the man until a review could be held. The officer checked the man throughout the night at intervals of between 10 and 15 minutes.
68. An officer conducted an ACCT assessment at 9.30am the next morning. The man said that the recent death of another prisoner had made him think of suicide but that this was not the only reason. He added that preparing a noose usually helped him to talk himself out of the intention to self-harm. He said that he did not want to die. In the afternoon, a senior officer and officer held the first case review. The man discussed his anxiety about his general health as well as his mental well being. He was also anxious about his ability to cope in the community when he was released. The senior officer recorded the level of risk as low, set an observation level of one per hour at night and arranged another review for the next morning, to be attended by the community psychiatric nurse (CPN) and the man's offender supervisor.
69. The second review took place as planned on 4 April, and was attended by the senior officer, the community psychiatric nurse (CPN), a further senior officer, a member of chaplaincy and the Head of Safer Custody. The man's offender supervisor sent a contribution by e-mail to the review panel. The man reported that he was stressed about his washing, which he insisted he needed to do by hand because he had a blood-borne virus. In spite of offers for his clothes to go in the prison wash, he remained adamant that he wanted to wash them himself. The CPN suggested he speak to a prison doctor and the man agreed. Observations were raised to every half hour during the evening and at night. A caremap was drawn up, with targets to arrange an appointment with the mental health team to discuss his medication and to address his anxiety about the transmission of blood borne viruses.
70. The next day, 5 April, the man's offender supervisor completed a resettlement checklist with him to identify plans in such areas as housing and employment. He told the investigator that he was not sure if the man was looking forward to leaving prison as he often changed his mind.

71. On 7 April, a prison doctor and the community psychiatric nurse (CPN) saw the man who told them he had stopped taking citalopram as he did not believe it was helping him. They discussed hepatitis C and the doctor tried to reassure him about its effect on others.
72. A senior officer chaired the review held on 8 April, and noted that the man was relaxed and said he had no thoughts of killing himself. He was also in a more positive frame of mind about his forthcoming release, after discussions with his offender supervisor and the prison doctor. Observations were reduced to three in the day and three at night.
73. At the next ACCT review on 11 April, the senior officer described the man as in a relaxed frame of mind and discussing his plans for his release. The community psychiatric nurse (CPN) noted the man had been paying off a debt to the Department of Work and Pensions and thought that this showed he was planning for his future. The ACCT procedures were then closed, with a post-closure review planned for one week later. The caremap was noted to reflect that the concerns had been addressed.
74. Later that evening, an officer responded to the man's cell bell. He told the officer that he had ripped sheets up and felt like hanging them around his neck, but told the officer not to worry as he was feeling all right. As the man's ACCT document had just been closed that afternoon, the wing manager agreed that staff could proceed to a case review, rather than complete a new assessment. Officers removed his belongings from the cell, in case he should use them to self-harm and he was offered the opportunity to telephone the Samaritans and see a Listener. He declined both offers. Staff were told to observe him hourly throughout the night.
75. The wing staff returned the man's belongings to him the next morning and the senior officer (SO) told him there would be a full ACCT review that afternoon. An hour later, the offender supervisor unlocked the man's cell for dinner and found him with a piece of torn blanket, which he was making into a noose. The offender supervisor spoke to him at length. He told the officer that he had fleeting thoughts about killing himself but did not know why. His observations were then increased to every half hour. In the review meeting, held on 12 April, he said that, although he had felt all right at the previous review, afterwards he felt that his safety net had been removed and this had increased his anxiety.
76. At the next review on 15 April, the man was described as in a good frame of mind and quite relaxed. His level of risk was assessed as low and the observations were reduced to every two hours. The community psychiatric nurse (CPN), who had attended most of the man's ACCT reviews at Risley, was not able to attend as he was given no notice. At interview, the senior officer said that the ACCT process was a safety net for the man. Because of this it was agreed that he should remain subject to ACCT monitoring until his release date on 22 June, even though his risk level was considered to be reduced. The offender supervisor told the investigator that he agreed with this

decision and said that, when the man was on ACCT monitoring, it seemed to be his, “comfort blanket, his safety zone, he did like people being there and being watched. And [if] he was taken off he would make sure he was put back on”.

77. Later that day, the man told the senior officer that he thought he was under threat from another prisoner because of an incident that had happened during a previous sentence. The senior officer said he reassured him and encouraged him to talk to him the following day if he felt the same. The man did so and he was then moved to another part of the wing so there would be little chance of him coming into contact with the other prisoner. The senior officer told the investigator he spoke to the man for some time and he told him he had no thoughts of self-harm at that point.
78. Two days later (17 April), the man told the senior officer that he still felt unsafe so he was moved to the reintegration unit (known as R1). The senior officer told the investigator the unit is for prisoners who find it hard to cope in the main prison and there is a higher staff to prisoner ratio than elsewhere in the prison, with two officers to 12 prisoners. He said the man seemed very keen on the idea and, at a case review on 19 April, the community psychiatric nurse (CPN) noted that the man had settled well on R1. He seemed relaxed and engaged well. The review team thought that his level of risk was low and reduced the observations to two conversations daily and two-hourly observations through the night. The next review was to be held on 3 May. Over the next few days, officers recorded in the on-going case record that the man spent time cleaning his cell, mixing with other prisoners and working well at the workshop. On 22 April, he told an officer that he was happier living on R1 unit.

### **Sunday 24 April 2011**

79. On 24 April, an officer noted in the man’s ACCT document that he was upbeat and positive and there were no issues to report. In a statement written to the Governor, the day after the man’s death, a prisoner said he had spoken to the man that day and he had told him that he was looking forward to his release in six weeks. He said he never seemed depressed or upset and his behaviour was no different that day. Another prisoner wrote a statement in which he said that he had also spoken to the man on 24 April, and he seemed fine.
80. An operational support grade (OSG) checked on the man at 10.40pm, by looking through the observation panel on his cell door. He told the investigator that he was watching television and appeared relaxed but he did not speak to him.

### **Day of the man’s death**

81. The man was subject to checks at intervals of no more than two hours as part of the ACCT monitoring. The OSG returned to the man’s cell at 12.25am and noticed that his observation panel had been covered from inside. He said that he tried to get a verbal response from him but got no reply. He then went to

the nearby office and telephoned the night orderly officer, who is in charge of the prison at nights. He waited on the landing and, approximately five minutes later, the orderly officer and his deputy arrived. He did not enter the cell at any point and told the investigator that it is normal practice to wait for assistance before entering a cell.

82. At interview, the night orderly officer for that evening said that he had received a radio message at approximately 12.25 pm, to attend the man's cell. He thought it had taken him a couple of minutes to get there from D wing. The OSG was standing outside and an officer had arrived on the wing at the same time as him. It is Risley's policy for three officers to be present when a cell is opened at night, unless in an emergency. .
83. The officer unlocked the cell but there was an obstruction. The staff then forced the door open a few inches and he saw the man hanging from the light fitting above the door, by torn bed sheets. He had wrapped himself in bed sheets and his mattress and his body blocked the door. The officer called 'Code Black' over his radio. (A code black is an emergency code indicating a prisoner with breathing difficulties). The incident log shows the call was made at 12.30am.
84. The officer told the investigator that he cut the bedding away from the light fitting and managed to squeeze into the cell. The man had made a hole in each corner of his mattress, wrapped it around himself and tied it with his bedding. He cut off the mattress to get to the man and then cut the ligature from around his neck. He noticed strips of bed sheets were tied around the man's wrists, knees and ankles and immediately cut them off. He was unresponsive.
85. The night orderly officer told the investigator that he left the cell, for a matter of seconds, to allow healthcare staff access to the wing. The nurse said that when she arrived the man's pupils were fixed and dilated and she could not feel a pulse. She noted that there was a ligature mark around his neck. She could not find a pulse in either his carotid or his femoral artery so immediately started chest compressions. An ambulance had been called (at 12.33am) and when paramedics arrived at 12.45am, they continued CPR until 1.17 when they pronounced the man dead.

### **Actions after the man's death**

86. Staff reviewed all prisoners subject to ACCT monitoring. A member of the staff care team was given the names of all the staff involved so they could offer support. The night orderly officer, the officer and the OSG said the Governor spoke to each of them individually that same night, but there was no hot debrief. The Governor issued notices to staff and prisoners informing them of the man's death.
87. Four prisoners who knew the man wrote statements for the Governor following his death. All four said that they had spent time with him over the previous days and he did not seem depressed or upset. Two of them thought

that there had been significant delays in staff attending the cell during the emergency.

88. One of the prison's management team and the prison family liaison officer went to visit the man's mother. There was no one at home when they arrived (at 6.53am), and they tried another address before returning to her home. They left a message with the Governor's telephone number.
89. The man's mother telephoned the prison later that morning and the Governor broke the news of her son's death. The prison's family liaison officer then returned to her home and spent some time with her and the man's brother. He explained what would happen next and that the prison would offer a contribution towards the funeral costs. A memorial service was held for the man at the prison, attended by the prisoners who knew him.

### **Post-mortem report**

90. A post-mortem and toxicology report was provided by the Coroner's office. The cause of death was "compression of the neck due to hanging" and there were no significant toxicological findings.

## ISSUES

### Clinical care

#### *Treatment for hepatitis and side effect of suicidal ideation*

91. Treatment for the man's hepatitis C began on 13 November 2009, and it was stopped almost a year later due to low white blood cell count. The clinical reviewer notes:

"The entries indicate that this treatment was being supervised by a consultant at the hospital and was being monitored by blood tests. There is evidence in the notes that the treatment dose was adjusted in line with the findings on the blood tests".

92. The man had concerns about his hepatitis condition, which he discussed with healthcare and unit staff. There is evidence that staff tried to allay his fears by giving him information on hepatitis, facilitating a meeting with the GP and reassuring him about washing his clothes. The clinical reviewer commented that the man's hepatitis was managed appropriately and we agree with his view.
93. The man had periods of depression and suicidal thoughts. The community psychiatric nurse noted that one of the side effects of interferon, prescribed to treat hepatitis C, was suicidal ideation. Neither the medical notes, nor the clinical review, give an indication of the potential impact of the drug on the man's propensity to self-harm. However, we note that he stopped taking it around six months before his death, so we do not consider that this had any bearing on his wellbeing at the time of his death.

#### **Mental Health**

94. The clinical reviewer believes the man's healthcare needs were, "sufficiently and appropriately assessed" throughout his time at Risley. He notes there was considerable input from the community psychiatric nurse into the man's care. On several occasions, he saw a psychiatrist and the prison doctor about his mental health. The clinical reviewer also notes the man, "was at times reluctant to engage with the mental health services" and often chose not to take medication.
95. Healthcare staff asked for someone from the prison psychology department to attend the man's ACCT reviews. The psychiatric nurse sought advice from an outside specialist service about a referral for possible personality disorder, but the service felt he did not meet their criteria for assessment. The clinical reviewer is of the opinion the "communication between the healthcare staff and other relevant professionals...was of a good standard".
96. The man's family believed that he had lost weight before his death and that weight loss, as well as growing a beard was one of the indicators of the state of his mental health. Healthcare staff recorded his weight periodically and

noticed some weight loss. It is not apparent that any specific action was taken about this, or that they were aware of the possible significance of his beard, but we are satisfied from the records that staff noted this and also took account, during ACCT reviews, of other signs when he appeared to be withdrawing from everyday interaction.

97. The clinical reviewer noted that the man had a history of mental illness and self-harm but he appeared to be stable when he arrived at Risley. He considered that his healthcare needs were sufficiently and appropriately assessed when he arrived. He said the care and treatment for hepatitis C and his mental health problems were of an adequate standard and concludes that his healthcare was an equivalent standard to expected provision in the community.

## **Suicide and self-harm prevention measures**

### ***Availability of ACCT documents***

98. The prison records given to the investigator did not contain all the man's ACCT documents. There are references to starting ACCT monitoring on seven separate occasions but, in spite of requests to the liaison officer, the prison was able to provide only three ACCT documents. We have been able to establish from the man's healthcare, chaplaincy and offender management records that ACCTs were opened and review meetings held. The community psychiatric nurse (CPN) and the mental health nurse, in particular, recorded ACCT review meetings in good detail in the man's medical record. However, the absence of ACCT documents means we have been unable to assess whether procedures were followed appropriately for most of the time that he was subject to ACCT monitoring.
99. It is important that staff have access to comprehensive information about a prisoner and the risk that he might pose to himself, particularly in cases of persistent self-harm. We are concerned that such important documentation has gone missing and that staff at Risley have not been able to locate it. We make the following recommendation:

**The Governor should ensure that all open and closed ACCT documents are stored appropriately and securely so that they can be retrieved and consulted when needed.**

### ***Management of the ACCT process***

100. From the documents available, it seems that the suicide and self-harm procedures were started promptly and at appropriate points when the man showed signs of vulnerability or acted on his suicidal thoughts. It is apparent that mental health staff had a good deal of input into his ACCT reviews. However, on a few occasions, the community psychiatric nurse (CPN) or the mental health nurse found that reviews had taken place or been cancelled without their knowledge. As the healthcare staff played an important role in

the man's welfare, it was important that they attended and had an input into ACCT reviews.

101. The community psychiatric nurse (CPN) also had to remind a senior officer about the importance of ACCT reviews being multi-disciplinary. As we have not seen copies of several of the ACCT documents, we do not know the number of times when reviews took place without multi-disciplinary representation. However, it is important that ACCT reviews are attended by as many of the people as possible who are involved in the prisoner's care, in order to give a fully rounded perspective.
102. We are also concerned about completion of the caremap. This is one of the most important elements of the ACCT process on which those responsible for supporting the prisoner determine and list the actions necessary to address the prisoner's issues and reduce his risk of self-harm. One of the periods of ACCT monitoring took place between 21 and 23 March 2011, when the man's level of risk was such that staff monitored him hourly during the day and twice an hour at night. However, only one action – for a doctor to clarify the contents of a hospital letter, was listed on the caremap and it remained unresolved. This is contrary to the ACCT guidance, which specifically states that they should not be closed until all caremap actions are complete. We make the following recommendation:

**The Governor should ensure that ACCT procedures are followed correctly and in particular, that all ACCT reviews are multi-disciplinary, appropriate caremap targets are set and checked at each review and that ACCTS are not closed until all the caremap actions are complete.**

### **Emergency response on the morning of the man's death**

103. An OSG checked the man at 12.25am, but could not see inside his cell because of the obstruction in front of the observation panel. He did not enter the cell as at that stage he did not know if there was any danger to life but he went to a nearby office to call for help. He told the investigator he was adhering to Risley's 'Night Operating Procedures' policy and it was clear at interview that he was familiar with elements of this policy.
104. The policy referred to by the OSG explicitly allows for staff to unlock a cell on their own, "... where there is, or appears to be, immediate danger to life...". This was reinforced by the Chief Executive Officer of the National Offender Management Service, who wrote to prison governors in January 2010. He reminded prisons that:

"Staff have a duty to of care to prisoners and to themselves and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger"

105. The OSG had a key for the cell in sealed pouch and could have used that key to open the man's cell. He explained that he would never enter a cell alone and that he would always wait for colleagues to arrive. In any case, he said when he checked his cell, he was only aware that he could not see into the cell, not that there was any reason to believe that the man's life was at risk. However, with hindsight, the fact that he was on an open ACCT, that his observation panel was obscured since the previous check and he was unresponsive when called, might well have indicated there was an immediate threat to life.
106. We are concerned that the OSG said that he would always wait for his colleagues before entering a cell and would never enter alone. In an emergency, time is of the essence and it is important that all staff who work in prison at night are prepared to enter a cell in order to preserve life. Staff can and should alert the night orderly officer when they are doing so, which helps to ensure safety. We therefore make the following recommendation:

**The Governor should ensure that all staff are aware that, subject to a personal risk assessment, and providing there is no obvious danger to themselves or others, they should enter a cell on their own at night in order to help preserve the life of a prisoner.**

#### **The safety of the man's cell**

107. On several occasions, the man told staff that he had threaded bedsheets through light fittings to see if it would be possible to hang himself from them. He told staff that the act of doing this usually convinced him not to hang himself. When he died, he was found suspended from a light fitting. It is of concern that he seemed to have considered or even practised the same method to try and harm himself a number of times. It would probably be impractical to replace all light fittings at Risley and, in any event, other potential dangers will remain in most cells unless they are entirely free of ligature points and all prisoners have their possessions removed. We understand that a subsequent death at Risley also involved a prisoner hanging himself from a light fitting. While we accept that risks will remain for most prisoners in most cells we consider that the Governor should check the cell light fittings in cells to assess whether any modifications can or should be made to help ensure safety. We make the following recommendation:

**The Governor should ensure that light fittings in cells are assessed to identify whether any modifications can be made to make them safer.**

#### **Debrief meetings**

108. Prison Service Order (PSO) 2710 (Follow up to deaths in custody), which was in force at the time of the man's death, states that all prisons should hold debrief meetings following a death. These meetings allow staff to identify any immediate issues of concern and to highlight any lessons that might prevent similar incidents. Although the Governor spoke to members of staff involved

in the emergency response individually, there is no record that debrief meetings were held.

**The Governor should ensure that debrief meetings are held after deaths and other serious incidents.**

## RECOMMENDATIONS

1. The Governor should ensure that all open and closed ACCT documents are stored appropriately and securely so that they can be retrieved and consulted when needed.

*Accepted*

*Wing Managers have been advised about correct storage of closed ACCT Documents as outlined in Chpt 5 of PSI 64/2011 – that ACCT documents must be stored in F2050 core record on completion. This advice was documented in monthly Safer Custody Meetings and further compliance will be monitored as part of Safer Custody spot checks of individual wings ACCT procedure compliance.*

2. The Governor should ensure that ACCT procedures are followed correctly and in particular, that all ACCT reviews are multi-disciplinary, appropriate caremap targets are set and checked at each review and that ACCTS are not closed until all the caremap actions are complete.

*Accepted*

*Head of Safer Custody has undertaken spot checks of ACCT Documents and any issues are raised with relevant wing managers. These are discussed and recorded at monthly Safer Custody Meetings. Safer Custody also undertake “Annex T” quality checks of ACCT Documents in which reviews, caremaps etc are monitored for compliance. Again this is discussed at Safer Custody meetings. However, given the concerns raised, Safer Custody are to introduce more regular checks of ACCT procedures with the introduction of a local quality check of documents to accompany the existing single management check introduced in PSI 64/2011.*

3. The Governor should ensure that all staff are aware that, subject to a personal risk assessment, and providing there is no obvious danger to themselves or others, they should enter a cell on their own at night in order to help preserve the life of a prisoner.

*Accepted*

*Night operating procedures were reviewed in July 2009 and Feb 2010 and implemented by way of LSI and LSS. This instruction comprises Risleys LSI 2.77 of the LSS and explains the procedure for unlocking cells during night patrol state. In Dec 2011 NOOs were contacted to confirm compliance and [the NOO on duty when this incident occurred] confirmed this and that the Night Patrols are in possession of this Instruction as part of the Folder they carry on duty. This instruction was also re-affirmed and continued compliance confirmed at Februarys Safer Custody Meeting*

4. The Governor should ensure that light fittings in cells are assessed to identify whether any modifications can be made to make them safer.

*Accepted*

*Head of Safer Custody to liaise with Head of Works and undertake physical checks of various light fittings (particularly on Birchwood Wing ) and assess options for modifications. Business case to be made on feasibility for undertaking any modifications*

5. The Governor should ensure that debrief meetings are held after deaths and other serious incidents.

*Accepted*

*Contingency plans (particularly for Deaths in Custody) are to be reviewed regarding recommendations for de-briefs after incidents. Following this all Governors, Orderly Officers etc will be contacted with the recommendations and advised to ensure that any relevant de-briefs are conducted accordingly.*