

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in  
November 2013 at HMP Nottingham**

## ***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 at HMP Nottingham in November 2013. He was 50 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the clinical care and treatment the man received at Nottingham. Staff at Nottingham cooperated fully with this investigation.

The man was remanded to Nottingham on 3 June 2013, charged with firearm offences. He was convicted on 11 July and sentenced to five years imprisonment. He had frequent contact with healthcare staff at Nottingham, was prescribed medication and had been referred to hospital for assessment for liver and gastric problems. He attended all the outpatient appointments arranged by the hospital. Although he was advised in September that he might have cancer, later tests suggested that he did not. He did, however, mention to a member of staff in October that he thought that he was going to die.

On the evening of 15 November, the man's daughter contacted Nottingham to inform staff that he had made calls to different family members to say 'goodbye'. She was very concerned that he would attempt to take his own life. Staff at Nottingham began suicide and self harm monitoring procedures. However, soon after, he was found hanging in his cell. Staff began cardiopulmonary resuscitation and called for an emergency ambulance. When paramedics arrived, they confirmed that he had died.

The man was clearly concerned about his health and his family subsequently expressed serious misgivings about the healthcare he received at Nottingham. However, the clinical reviewer concludes that, while it was clearly distressing for him not to have a confirmed diagnosis, the standard of healthcare he received was equivalent to that he might have expected in the community.

It is not clear to what extent the man's actions were motivated by concerns about his physical health, but he was clearly distressed on 15 November and suicide and self-harm monitoring was begun appropriately after his family expressed concerns. However, while, staff at Nottingham assessed his level of risk as raised, they reduced the level of observations, even though he had a history of attempting suicide. I am concerned that the suicide and self-harm prevention procedures were not better used to provide more sustained and effective support. I am also concerned that an ambulance was not called immediately when he was found, although I am pleased to note that the Governor has now issued an instruction to staff to ensure that this does not happen in the future.

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.

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## SUMMARY

1. The man had a history of depression and a history of self-harm. He had previously been an inpatient in a psychiatric unit and attempted suicide twice in 2012. He had been in prison before, but some 20 years previously.
2. On 3 June 2013, the man was charged with firearm offences and remanded into custody. On 11 July, he appeared at Crown Court and was sentenced to five years in custody.
3. On 26 August, a prison doctor referred the man to the hospital because blood tests results, and his physical presentation, indicated that he might have abnormalities with his liver. He attended all the hospital outpatient appointments arranged by the consultant responsible for his care. Although he was advised in September that he might have cancer, later tests suggested that he did not. He did, however, mention to a member of staff in October that he thought that he was going to die.
4. On 15 November, the man's daughter telephoned Nottingham to say that his family had all received 'Goodbye' telephone calls during the course of the day and she was very concerned that he might harm himself. This information was immediately passed to the staff on the wing. Officers began to monitor him under suicide and self-harm prevention measures.
5. A prisoner went to see the man in his cell. He could not push the door open, even though it was unlocked, and called to an officer for help. The officer opened the door, found him hanging in his cell and called for emergency medical assistance. Control room staff did not call an ambulance immediately. Officers and healthcare staff performed cardiopulmonary resuscitation (CPR) until paramedics arrived. Paramedics took over his care but they pronounced him dead at 3.37pm.
6. The investigation found that suicide and self-harm monitoring (known as ACCT) did not provide the support that the man needed. We consider the level of observations should have been increased not decreased at a time of heightened risk and that the observations were too predictable. A post-closure interview for a previous ACCT was not held as it should have been. We are also concerned that an ambulance was not called automatically, but as a result of feedback from this investigation, the Governor has now issued appropriate instructions about this issue. We make one recommendation.

## THE INVESTIGATION PROCESS

7. The investigator visited Nottingham on 26 November 2013 and obtained the man's prison record. Notices were issued to staff and prisoners inviting anyone with information to contact him. He met the Governor and the Chair of the Independent Monitoring Board. He interviewed 11 members of staff and one prisoner and sent written feedback about preliminary findings to the Governor on 10 February.
8. NHS England appointed a clinical reviewer to assess the man's clinical care at the prison.
9. The investigator contacted Her Majesty's Coroner to inform her of the investigation and request a copy of the post-mortem report. This report has been sent to the Coroner.
10. One of our family liaison officers contacted the man's family to inform them about the investigation and to invite them to identify issues which they wanted the investigation to consider. The investigator and family liaison officer visited family on 20 December. They had the following questions and concerns:
  - They contacted the prison by telephone following visits as they were concerned about his health. They wanted to know if these calls were followed up.
  - Why was he not given regular blood tests after the onset of his symptoms?
  - They believe that prison doctors refused to see him after officers had made an appointment.
  - Was he prescribed the correct medication and pain relief?
  - Was there an appropriate risk assessment for him to have medication in his cell?
  - Why was he not taken to hospital each time he collapsed?
  - Why was he referred to hospital?
  - What were the outcomes of the hospital examinations?
  - What information was provided to the prison doctors?
  - Why did the prison doctors at Nottingham not chase up the hospital?
  - They believe that the failure of care given by Nottingham was the reason that he took his own life.
11. The details of the care the man received are contained within the key events section of the report, and the assessment of that care is found in the issues section of the report. His family received a copy of the draft version of the report as part of the review period. Having considered the investigation findings, his family pointed out one factual inaccuracy in the investigation report which has now been amended. They explained they had a number of questions about his clinical care which they would be taking forward at the inquest.

## **HMP NOTTINGHAM**

12. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire. It holds over 1,000 remanded and sentenced prisoners.
13. Nottinghamshire Healthcare Trust provides the healthcare at the prison. There is no inpatient healthcare unit. Prisoners who need nursing care are located in what is known as an enhanced care area (ECA) on F wing, where nurses are on duty 24 hours a day.

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

14. The last report published on Nottingham by HM Inspectorate of Prison was an unannounced short follow up inspection in February 2013. The report noted that too few staff had completed the safer custody awareness training and Assessment, care in custody and teamwork (ACCT) case reviews were not always adequately multidisciplinary. The care plans for prisoners were individualised but the quality of recording of the interactions with those on ACCT documents varied widely. Inspectors noted that the prison had not achieved a recommendation that triage algorithms should be introduced to ensure consistency of treatment.

### **Independent Monitoring Board**

15. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent report, for the period ending 28 February 2013, the IMB reported that the prison has no in-patient care provision and that prisoners requiring that level of care are transferred to the appropriate hospital.

### **Previous deaths at Nottingham**

16. The man's death was the second self-inflicted death to have occurred at Nottingham since 2010. There are no similarities between his death and the previous death.

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

17. 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 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 monitor and supervise the prisoner. Support for prisoners includes setting a number of significant interactions with them during the day, supplemented by checks on their well-being during the times they are locked in their cell. Part of the ACCT process involves assessing immediate needs and drawing up a care-map 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 the actions of the care-map have been completed, and a review should be held within a week of the ACCT being closed.

## KEY EVENTS

18. The man was born in November 1963. He suffered from depression and had a history of self-harm. He had spent time as an inpatient in a psychiatric unit and attempted suicide twice in 2012. He had last been in prison 20 years previously.
19. On 3 June 2013, the man was remanded into custody, charged with firearm offences. When he arrived at Nottingham, he saw a nurse, who conducted the initial healthscreen (this takes place every time a prisoner arrives at a prison to determine any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner might pose of harming himself or attempting suicide).
20. The man told the nurse that he had previously been a patient in a psychiatric unit and had tried to take his own life twice in 2012. In April 2012, he had taken an overdose of medication with alcohol and, in May 2012, he had deliberately driven a car at a lamppost. He told her that he had thoughts of taking his own life now that he was in prison. He gave the name and address of his community doctor and said that he was not on any prescribed medication.
21. The nurse opened an ACCT document and also referred the man to be seen by a member of the mental health team the following day. A prison GP prescribed him one night's dose of zopiclone (for insomnia).
22. A Supervisory Officer (SO) completed the ACCT immediate action plan which stated that staff should observe the man hourly until the first case review. He was told how to access the Samaritans and the Listener service. (Listeners are prisoners trained by the Samaritans to provide support to other prisoners in crisis.)
23. A member of the mental health team saw the man at 10.26am on 4 June. He told her that he had thoughts of taking his own life because he was missing his family. He said that he had been a voluntary inpatient in a psychiatric unit in April 2012 and had been diagnosed as suffering from depression. He said he had last been prescribed medication in June 2012.
24. That afternoon, at 2.55pm, an officer conducted the ACCT assessment interview with the man. He said he felt low and was nervous about becoming depressed as he had attempted to take his own life twice the previous year and felt he might need antidepressants. He said he worked full time before coming to prison, had three grown up children and had a relatively new relationship with his girlfriend, but was unsure how this would work out now he was in custody. He said that he had no immediate thoughts of self-harm or suicide.
25. Later that afternoon, a custodial manager chaired the first ACCT case review. An officer, SO, a nurse and the man were also present. He said that he was confused as prison life had changed so much since his last time in custody. He said he had a history of depression but was not currently prescribed any medication. He said he tried not to think about harming himself. His level of risk was assessed as low and the level of observation was changed to one observation morning, afternoon and evening and hourly during the night, with a further case review to be held seven days later.

26. The custodial manager completed the ACCT caremap and identified three actions. These were that the man should be given a physical and mental health assessment, be referred to the optician and make applications for employment and the gym.
27. On 7 June, a nurse saw the man for a mental health review. He told the nurse that he was back in custody on firearm offences and was worried that the behaviour of another close family member might result in prison. He said that his first wife, with whom he had three children, left him five years before and had since remarried. His second wife left him during 2012 and this sent him "off the rails", resulting in him twice attempting to take his own life.
28. The nurse recorded that the man's community records confirmed that his only prescribed medication in 2013 had been two short courses of zopiclone. He also recorded that he was tearful, very low and had suicidal thoughts. He recommended that he should be prescribed antidepressants. A doctor prescribed 20mg citalopram (an antidepressant).
29. On 11 June, a custodial manager chaired an ACCT review. A SO and the man also attended. A nurse had updated the custodial manager by telephone that he had been seen by healthcare staff, that a mental health assessment had been completed and he had been prescribed antidepressants. He said that he had visits from his family and still had fleeting thoughts of self-harm, but had no plans to act on them. He said that he had settled on the wing apart from the fact it was full of younger prisoners. The custodial manager reviewed the ACCT caremap and added a further action to transfer him to F Wing, which houses prisoners aged over 50. His level of risk was still assessed as low and the level of observation remained unchanged, with a further review to be conducted in seven days time.
30. On 18 June, a custodial manager chaired an ACCT review at which a nurse and the man were present. The custodial manager recorded that all the actions in the caremap had been completed. The man had been transferred to F Wing, had a job in the recycling workshop and could use the gym. They agreed that the ACCT should be closed and he was told that he could seek the support of the staff or Samaritans at any time. The ACCT post-closure review was scheduled for 25 June. However, the post-closure form in the ACCT document is blank and there is no evidence that the review was completed.
31. The same day, a member of the mental health team saw the man for a mental health review. He said that he had not felt any benefit from the citalopram and had experienced stomach pain after eating for the past four to five days. The nurse advised him that it would take time before he felt the benefit of the citalopram and encouraged him to continue taking it. The nurse also referred him to be seen by the doctor.
32. On 26 June, the man saw a doctor, as arranged by a nurse. He said that he experienced gastric pain 30 minutes after eating. The doctor recorded that he smoked, had been an average drinker and was stressed at being in prison. The doctor diagnosed gastritis and prescribed omeprazole (for gastric conditions) and planned to review him in one month's time. The doctor recorded his weight as 66.8kg (10st 7lb).

33. On 27 June, a member of the healthcare team completed an in-possession medication assessment. He found that the man was suitable for keeping his medication in his cell. On 11 July, he was convicted at Crown Court and sentenced to five years in custody.
34. On 24 July, a doctor saw the man to review his gastric pain. He said that his appetite was good and he no longer experienced any gastric pain. The doctor recorded that his weight was 67.5kg (10st 9lb).
35. On 6 August, the man saw another prison doctor complaining of gastric pain which he said had increased over the past few days after he had vomited. The doctor took blood samples to test for helicobacter pylori (a bacterium that infects the lining of the stomach and duodenum). The samples were negative. The doctor prescribed peptic liquid (an antacid), to be taken four times a day, in addition to the omeprazole.
36. On 14 August, the man saw a nurse, a member of the mental health team, for a mental health review. He said that he felt stable in mental state and mood and did not want any further mental health support. She checked that he knew how to get mental health support if he felt his circumstances changed.
37. On 23 August, the man saw a doctor, complaining of having dark urine and loose pale stools. The doctor recorded that his eyes were slightly yellow and arranged for blood tests to be done immediately and sent him to hospital for analysis. He recorded his weight as 65kg (10st 3lb).
38. The results of blood tests were returned to the prison that evening. The doctor reviewed the results at 8.47pm and recorded that the man had an abnormal liver function. The doctor noted that as healthcare was now closed for the weekend, he should be seen in the clinic the following Monday. He suspected that a referral to a hepatologist (a specialist in liver, pancreas and gallbladder problems) would be needed.
39. On Saturday 24 August, the man's ex-wife called the prison and spoke to a custodial manager. He said that the man's daughter had visited him and that he was suffering with a liver condition and looked yellow. The custodial manager recorded on the prison computer record that he had advised the man's ex-wife that he would report her concerns to the medical team. He also recorded that the medical team had told him that they were aware of the man's condition.
40. On Monday 26 August, a doctor saw the man and referred him to a consultant hepatologist. The doctor also recorded that he looked jaundiced (which meant that there was a yellowish pigment to the skin and eyes).
41. On 30 August, the hospital informed the prison that the man had an appointment for 2 September. That evening he fainted twice, at 5.09pm and at 6.43pm. A nurse responded and found him alert and orientated. He said he had felt unwell and faint. The nurses recorded his blood pressure as 130/70 at 5.09pm and 132/78 at 6.43pm. (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is

classed as high and a reading of 90/60 or below is classed as low.) The duty doctor advised staff to monitor him and to call him if his condition deteriorated.

42. The Head of Reducing Re-offending and Industries told the investigator at interview that she had taken a call from the man's daughter. She said that she could not remember the date of the call, and that she did not make an entry in his prison computer record. She said that she was duty governor and it was evening time when his daughter rang because she was concerned about his health. During a visit, he looked unwell, his health was deteriorating and his family were concerned that he was not getting the care that he needed. She said that she explained that she was not responsible for healthcare, but would pass on the family's concerns. She said she contacted the Head of Healthcare by e-mail to pass on their concerns and to ask that he received whatever medical care he needed. She said she received a response to say that he had seen the doctor and that they were aware of his condition. There is no record of this discussion in the medical record.
43. On 2 September, the man saw a consultant hepatologist at the hospital. The consultant recorded that he had both ultrasound and a computerised tomography (CT) scans (which uses X-rays and a computer to create detailed images of the inside of the body) of his chest, abdomen and pelvis. These tests indicated that he had enlarged lymph nodes. The consultant also recorded that he had told him that he might have cancer of the bile ducts or lymph nodes, but also that he might have stomach ulcers. Further tests were required. The consultant prescribed an increase in omeprazole from 20mg to 40 mg. A letter from him arrived at Nottingham on 4 September outlining these findings.
44. On 16 September, the man attended the endoscopy department at hospital. A consultant hepatologist examined him and recorded that the initial results suggested that he had cancer. A biopsy was taken. The consultant prescribed a course of antibiotics (co-amoxiclav) and suggested the prison doctor prescribe pain relief; the doctor prescribed co-codamol.
45. On 19 September, a workshop discipline officer contacted the healthcare unit as he was concerned about the man's health. The officer said at interview that he was told that he had an appointment with a doctor the following morning.
46. On 20 September, the man saw a doctor as he was concerned about his antidepressant medication. The doctor recorded that his prescribed dose of 20 mg of citalapram was at the low end of the range and was appropriate for patients with impaired liver function.
47. On 23 September, the man saw a doctor, complaining of nausea and diarrhoea. The doctor recorded that he was still jaundiced and had lost weight. His weight was recorded as 59.7kg (9st 6lb). The doctor prescribed dihydrocodeine (moderate pain relief), metoclopramide (for nausea) and Ensure Plus (a liquid nutrition supplement).
48. The same day, an officer recorded in the man's prison computer record that his ex-wife had telephoned the prison as she was concerned about his health after visiting the previous day. The officer told her that her concerns would be passed on to healthcare staff. A nurse recorded in his medical record that his

ex-wife wanted information about his treatment and care. He was asked to contact his ex-wife because of patient confidentiality.

49. On 24 September, a doctor wrote to healthcare staff at Nottingham to confirm that there was no evidence of lymph node cancer. However, he added that a further biopsy of the liver was needed for a full diagnosis.
50. On 7 October, the man went to hospital for the liver biopsy. The consultant hepatologist wrote to him on 16 October (the letter was received by Nottingham on 21 October and given to him). The consultant said that the results from the biopsy had not produced a conclusive diagnosis and that further tests would be arranged.
51. On 23 October, The man saw a doctor, as he was fed up of not having a diagnosis from the hospital. The doctor recorded that he was waiting for a further biopsy and that his weight had dropped further to 56.4kg (8st 12lb). He prescribed a change in antidepressant medication from citalopram to mirtazapine and requested an urgent mental health review.
52. On 24 October, a nurse saw the man, as requested by the doctor. The nurse recorded that throughout the entire consultation he sat with his head in his hands. He said that he had lost a lot of weight since being in prison, was waiting for a further hospital appointment but was not hopeful for his prognosis and felt that he was going to die. At interview, the nurse said that they had discussed the change in antidepressant medication. The nurse told him he would be reviewed in two weeks.
53. On 1 November, the man saw a doctor, as his stomach pain was worse at night. The doctor recorded that his weight was 56.4kg (8st 12lb), prescribed fentanyl (slow release pain relief patches) instead of dihydrocodeine and added docusate (a laxative). He asked for his weight to be checked weekly.
54. On 7 November, the man fainted while out in the prison grounds with the recycling team. Officers asked for assistance from the healthcare team and two nurses responded. They found him alert and orientated. He said that he had not eaten any breakfast and had not collected his morning medication. A nurse recorded that he had not lost consciousness, his blood pressure was 129/77 and he was waiting for further hospital investigations. He walked back to his cell unaided and his medication was taken to him.
55. On 8 November, the Head of Offender Management recorded in the man's prison computer record that he had received a telephone call from the man's ex-wife as she was concerned about the deterioration in his health. He said that he would pass on her concerns to the healthcare team. He told the investigator that he had explained to her that the medical side of the prison was run by the NHS and that medical information was confidential. The healthcare team told him that the man was being seen by the doctors at the prison and was due to have a hospital appointment.
56. On 9 November, a nurse checked the man's weight and blood pressure. She recorded his blood pressure as 128/70 and weight as 55kg (8st 9lb).

57. Early on the morning of 12 November the man saw a doctor, complaining of nausea, poor sleep and that he was low in mood. The doctor prescribed an increase in mirtazapine from 30mg to 45mg and added prochlorperazine (for nausea and restlessness). The doctor recorded his weight as 55.4kg (8st 10lb). Later that day, he attended hospital for a further endoscopic ultrasound.
58. On 15 November, the man went to work in the morning as usual. An officer said at interview that he appeared his usual self. However at approximately 5.50pm, his daughter telephoned Nottingham to say that his family had all received 'Goodbye' telephone calls during the course of the day and she was very concerned that he might harm himself. This information was immediately passed to the staff on the wing.
59. An officer went to see the man. He opened an ACCT at 6.00pm, and recorded that he was very tearful. He told the officer that his girlfriend had finished with him and a family member had had a miscarriage. He also said that he was suffering from a terminal illness. He said that he would not do anything silly but mentioned that he had tried to take his own life in the past.
60. A SO completed the ACCT immediate action plan, made the man aware of the Samaritans and Listener service and referred him to the mental health team. The level of observations was set at hourly until the ACCT assessment the next day. Staff checked on him hourly throughout the night and no concerns were recorded. All of the checks were recorded as being done on the hour, with the exception of two checks at 10.50pm and 11.05pm.

### **Events leading up to the incident**

61. At 8.00am, an officer checked on the man and recorded that he was in bed, lying on his left side and appeared asleep. He unlocked the cell at 9.00am and did not record any concerns about him. He recorded that the man collected his morning medication at 10.00am.
62. The officer conducted the ACCT assessment interview with the man at 10.50am. He explained his family problems. He also said that, although he spoke to his children by phone, he felt that everyone could get on with their lives without him. He said that he felt that the healthcare team at Nottingham was letting him down and that no-one was telling him anything about his illness. He said he saw mental health staff but felt that they did not help.
63. At 11.20am, a SO held the first ACCT case review with the officer and the man. No one from the healthcare team was present or had been contacted. He explained his family issues, said that he was waiting for test results and felt unsupported by the healthcare team. He again said that everyone could get on with their lives without him. The SO recorded in the record of the review that he was "very low in mood, very depressed". His level of risk was assessed as raised, but the level of observation was reduced to every two hours during the day and then hourly during the night, with a further review to be held two days later.
64. The SO completed the ACCT caremap which identified three actions: an appointment with mental health, an appointment with healthcare and for the man to keep in contact with his family.

65. At 12.45pm, an officer checked on the man and raised no concerns. At 1.30pm, the officer unlocked his cell so he could attend afternoon association and exercise. However, he said that he did not want to go outside for exercise. His door was left unlocked.
66. At 3.12pm, a fellow prisoner and friend went to see the man in his cell for a chat and a smoke. When he tried to push the cell door it would not open. He immediately called to the officer for help.
67. The officer ran to the cell, followed by a colleague, and was able to open the door sufficiently to find the man immediately behind the cell door. The officer found that he was in a sitting position with a ligature, made from boot laces, around his neck.
68. The other officer radioed a code blue emergency (which indicates a prisoner is not breathing or is unconscious). The entry in the Communications Room Incident Log states that he radioed at 3.13pm. The first officer, a retained fire-fighter and first aid instructor, cut the ligature and immediately commenced cardiopulmonary resuscitation (CPR). East Midlands Ambulance Service records show that they received a 999 call at 3.16pm.
69. A nurse arrived at the cell and took over CPR. She was assisted by the first officer. An automated external defibrillator (AED - which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary) was used but advised that there was no shockable rhythm. The resuscitation attempt continued until paramedics arrived at 3.26pm and took over the man's care. The paramedics pronounced that he had died at 3.37pm.
70. As with all deaths in prisons, the police undertook an initial investigation to check whether a criminal investigation is necessary. The police found letters in the man's cell, written to his children, ex-wife and ex-partner in which he said he that he no longer wished to live and wanted each of them to live their lives as they wanted to.

### **Contact with the man's family**

71. Two prison family liaison officers were appointed. They visited the man's daughter, his nominated next of kin, at 6.45pm to break the news and explain the circumstances of his death and to offer support. They kept in contact with the family to provide ongoing support and offered financial assistance towards the funeral expenses.

### **Support for staff and prisoners**

72. The Governor chaired a hot debrief at 6.00pm for the staff involved in the emergency to discuss what had happened and to offer support. The services of the prison's care team were made available.
73. Officers and members of the chaplaincy supported prisoners affected by the incident. Prisoners subject to suicide and self-harm monitoring were reviewed in case they had been adversely affected by the man's death.

## **Post-mortem**

74. A post-mortem examination was conducted and found that the cause of the man's death was asphyxia due to hanging. However, it was also found that he had autoimmune pancreatitis (a condition which inflames the pancreas) and cholestatic liver disease (a condition which causes an obstruction in the bile duct). The pathologist commented that death was due to unnatural causes.

## ISSUES

### Assessment of risk

75. When the man arrived at Nottingham, members of staff identified that he was at risk of suicide and self-harm and opened an ACCT. His risk factors for suicide and self-harm included his previous deliberate self-harm, his previous suicide attempts, his remand status and that he had just arrived in custody. This ACCT was managed with a multidisciplinary approach and was appropriately closed as each of the caremap actions had been completed. However, the ACCT post-closure interview did not take place as required by the mandatory instructions contained in Prison Service Instruction (PSI) 64/2011.
76. On 15 November, an officer opened an ACCT after the man's family had contacted Nottingham following the 'goodbye' calls he had made to family members during the day. We believe that this response was appropriate, although we are surprised that some earlier indications that he was very distressed seem to have been missed. The next morning, on 16 November, during the ACCT assessment interview, he said his family were better off without him. He reiterated this at the first case review, at which there was no input from the mental health team. Despite this, and his previous suicide attempts, the level of observations was reduced to every two hours during the day and hourly throughout the night. There is no evidence that the risk of him holding medication in his cell was reviewed after he was assessed as at risk of suicide and self-harm.
77. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. A prisoner's presentation is obviously important and reveals something of their level of risk, but all risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged and responded to effectively. However, we consider that the indicators of increased risk displayed by the man were such as to suggest that the level of observations should not have been reduced. We do not believe that checks every two hours were sufficient to support a prisoner who had recently said that he intended to take his own life.
78. PSI 64/2011 also says that ACCT observations should be at irregular intervals. It is important that checks are conducted at random intervals within the specified frequency otherwise prisoners can predict a window of opportunity if they are planning to take their own life. However, on the night of 15-16 November, the checks were mostly done on the hour and were therefore too predictable.
79. Overall, we consider that, although staff opened an ACCT, they did not give the man sufficient active support or help manage and reduce his level of risk of suicide and self-harm. He was evidently extremely concerned about his health yet no one from the healthcare team was invited to his first ACCT review and there was no indication of any urgent attempt to get him the support he evidently needed. We make the following recommendation:

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

- **A multidisciplinary approach for all case reviews;**
- **Assessing the level of risk and recording the reasons for decisions;**
- **Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;**
- **Conducting observations at random intervals within the specified frequency;**

## **Clinical Care**

80. We are satisfied that the man's family's concerns about his health were passed on to healthcare staff at the prison when they were brought to the attention of prison staff, although they were not always well recorded or reflected in his medical notes. There is no evidence that prison doctors refused to see him at any time and records indicate that he attended all GP appointments at the prison and all scheduled hospital appointments. On 19 September, an officer contacted the healthcare department as he was concerned about his health. As he was due to see the doctor the next morning, a further appointment was not made. We consider that this was appropriate.
81. The clinical reviewer examined the standard of healthcare the man received at Nottingham. He believes that he was appropriately assessed on the day of his initial reception at Nottingham and when he subsequently presented with minor problems. On 26 August, a doctor appropriately referred him to be seen urgently by a hepatologist within two weeks. A hospital consultant saw him on 2 September. The clinical reviewer considered that he received appropriate medication and pain relief.
82. The man was seen regularly throughout his time in Nottingham by a variety of healthcare staff, including mental health nurses. In the week before his death he was seen by a doctor. The clinical reviewer is satisfied that on the occasions when he fainted, he never lost consciousness and healthcare staff always took a full set of physical observations. With his history, the clinical reviewer believes that the healthcare staff acted correctly in not referring him to hospital on each of these occasions.
83. The clinical reviewer notes that the man attended all his hospital appointments and that investigations proceeded in a timely manner and correspondence was maintained between the hospital and prison healthcare. While hospital tests continued, there was no firm diagnosis that the prison healthcare staff could convey to him. The clinical reviewer recognises that the lack of any confirmed diagnosis would have been distressing for him and his family, and frustrating for healthcare staff and the consultants at the hospital, who were responsible for his care. The clinical reviewer's opinion is that the standard of care he received while at Nottingham was equivalent to that of an NHS patient treated in the community.

## **Emergency Response**

84. An officer radioed a code blue emergency at 3.13pm, but an ambulance was not called until 3.16pm. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes provides guidance to staff on communicating the

nature of a medical emergency and ensuring there are no delays in calling ambulances. Paragraph 5.4 says:

*“A representative NHS Ambulance guide for use in the community states that an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking, fitting or concussion, severe allergic reactions or a suspected stroke. This must also be the case for prisoners and therefore, in these situations when the emergency is called over the radio network an ambulance must be called immediately.”*

85. PSI 03/2013 was issued on 1 February 2013 and required all governors to have a medical emergency response code protocol based on the instruction by 28 February 2013. In response to our initial feedback following this investigation, the Governor issued a new operational instruction (02-2014), which sets out the requirements specified in PSI 03/2013, and specifically requires the control room to call an ambulance automatically when an emergency code is used. As this issue has been addressed, we do not make a recommendation.

## **RECOMMENDATIONS**

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Multidisciplinary approach for all case reviews;
  - Assessing the level of risk and recording the reasons for decisions;
  - Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p>The Governor 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>a) Multidisciplinary approach for all case reviews;</li> <li>b) Assessing the level of risk and recording the reasons for decisions;</li> <li>c) Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;</li> </ul>	Accepted	<p>Governors Order to be published instructing the process to be followed regarding reviews, risk level assessments and justifying decisions and frequency of reviews and levels of observations.</p> <p>The safer custody team will monitor the progress and discuss these in the safer custody meetings.</p>	14 April 2014	