



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in April 2014,
while a prisoner at HMP Featherstone**

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 from hanging of a man at HMP Featherstone in April 2014. He was 37 years old. I offer my condolences to his family and friends.

A review of the clinical care and treatment the man received at Featherstone was undertaken. The prison cooperated fully with the investigation.

The man arrived at HMP Featherstone on 13 March 2014, after transferring from HMP Stoke Heath. Staff at Stoke Heath had started suicide and self-harm prevention procedures three days previously. He had been distressed after reporting that other prisoners, who thought he had concealed drugs internally, had sexually assaulted him.

At first, the man appeared to settle at Featherstone, but on 31 March, a chaplain was concerned that he was suicidal. The next day, he told a mental health nurse that he would hang himself if his problems were not resolved. Staff increased the frequency of his observations and reviewed his risk and support plans the next day. He said he was in debt to other prisoners for tobacco and wanted to move to another prison. He was also worried about his father's health. The review agreed plans to address these concerns.

On 3 April, the man attempted to jump over the stair banisters above the stairwell. Officers pulled him back onto the landing and took him back to his cell. No one reviewed his risk after the incident. In the early hours of the next morning, staff found him on the floor of his cell with a tight ligature around his neck. The staff did not attempt resuscitation, as it was apparent that he was dead.

I recognise that the man's actions that evening would have been difficult for staff at the prison to predict, but I am concerned that there were a number of deficiencies in the operation of suicide and self-harm prevention procedures, which, if implemented properly, might have led to better identification of his risk and more effective support. I am concerned that, despite his identified risk, he did not have a full mental health assessment. While it does not appear it would have affected the outcome for the man, it is unacceptable that for each of the last three deaths at Featherstone, I have had to make a recommendation about the need for staff to call an ambulance immediately in a life-threatening situation. The Governor needs to make active efforts to ensure that all prison staff follow mandatory emergency procedures.

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

December 2014

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SUMMARY

1. The man had spent many years in and out of prison. He was serving a sentence for robbery and theft when he transferred from HMP Stoke Heath to HMP Featherstone on 13 March 2014, after he had reported that other prisoners had sexually assaulted him. It appears that his alleged assailants suspected that he had drugs concealed in his rectum. Stoke Heath started Prison Service suicide and self-harm prevention procedures (known as ACCT) after his reported the assault.
2. At an ACCT case review on the morning of 14 March, staff assessed the man's risk of suicide and self-harm as raised. He said that he did not intend to harm himself. At his next ACCT review, three days later, he said he was feeling much more settled and the review assessed his risk as low.
3. ACCT reviews on 24 and 31 March, continued to regard the man as low risk. On 1 April, he told a mental health nurse that he had been promised a move to a new prison and, if this did not happen soon, he would hang himself. He showed the nurse a noose that he had made from a torn bed-sheet. Staff held an immediate ACCT review and now assessed his risk as raised. They increased the frequency of observations and arranged another ACCT review for the following day.
4. At the ACCT review on 2 April, the man reported a number of problems: the sexual assault, concern about his father's health and being in debt to other prisoners for tobacco. He asked about moving to a prison out of the area and the staff told him that that they would look into this as a possibility. (His prison records show that he had a history of getting into debts and a tendency to self-harm as a way of relieving stress.)
5. On 3 April, a supervising officer spoke to the man to let him know what the prison was doing to help deal with his problems. This included getting him sufficient tobacco to deal with his debts. The man thought he would be moving to the segregation unit, but the officer told him that that was not part of the support plan. He then left the wing office and climbed over the banister rail above the stairwell as if to jump. Officers pulled him back onto the landing and took him back to his cell, which was a single cell.
6. Staff checked the man once an hour and he appeared well throughout the evening of 3 April. At 2.45am, a night patrol officer noted he was watching television. When a patrol officer checked the man an hour later, he was lying on the floor with his bed standing on end. Some cord was tied tightly around his neck, which appeared to have snapped away from the bed frame. One of the patrol officers radioed an emergency medical code to indicate a life-threatening situation. The night orderly officer in charge of the prison asked the staff to wait for him to arrive before they went into his cell. When he arrived, the night orderly officer examined the man and found no signs of life. He concluded that the man was dead and that they should not attempt resuscitation. A paramedic arrived around 20 minutes later and, after examining the man, pronounced him dead.

7. While it would have been difficult to predict the man's actions in the early hours of 4 April, the investigation found that his ACCT reviews were not sufficiently multi-disciplinary. Observations at night were at too predictable intervals and when the man threatened to throw himself from the landing on the afternoon of 3 April, staff should have held a review to discuss whether he needed further support and to reassess his risk. When the night patrol officers found the man hanging, we consider that they should not have waited for the orderly officer before going into the cell, in case emergency treatment was possible. We make five recommendations.

THE INVESTIGATION PROCESS

8. We issued notices to staff and prisoners at HMP Featherstone informing them of the investigation and inviting them to contact the investigator if they had relevant information. No one responded.
9. On 8 April 2014, the investigator visited Featherstone and obtained copies of the man's prison and healthcare records. He subsequently interviewed 13 members of staff and two prisoners at Featherstone.
10. The investigator informed HM Coroner for Staffordshire (South) District of the investigation and we have sent him a copy of this report.
11. NHS England (Shropshire and Staffordshire) appointed a clinical reviewer to review the man's clinical care at Featherstone.
12. One of the Ombudsman's family liaison officers contacted the man's mother to inform her of the investigation. She had no specific issues she wanted the investigation to take into account. She received a copy of the draft report but did not make any comments.

HMP FEATHERSTONE

13. HMP Featherstone is a medium secure prison in the West Midlands. It holds up to 687 men in seven house units.
14. Staffordshire and Stoke on Trent Partnership NHS Trust run healthcare services. There is no inpatient facility. Healthcare staff dispense medication to prisoners from treatment rooms on each house unit.

HM Inspectorate of Prisons

15. The most recent inspection of Featherstone was in October 2013. Inspectors found that there was a good range and quality of work and education for prisoners, which created a purposeful atmosphere. Relationships between staff and prisoners were generally good. Inspectors noted there was clear problem with prisoners being in debt to other prisoners, linked to the availability of drugs and tradable medicines. This led to bullying. Inspectors found that the prison was good at identifying risk of suicide and self-harm and the staff appeared caring. However, there were important shortfalls in the quality of ACCT documents: most caremaps were inadequate; there was inconsistent case management; reviews lacked multidisciplinary input and were not well recorded; observations were not always at the required frequency.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its annual report for the period to November 2013, the Board was concerned about the availability of illegal substances in the prison and that this led to bullying and prisoners getting into debt.

Assessment, care in custody and teamwork (ACCT) procedures

17. Assessment, care in custody and teamwork (ACCT) procedures is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT process 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 at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous Deaths

18. There have been four other self-inflicted deaths at Featherstone since 2004, when the Ombudsman began investigating deaths in prison. There has been no other self-inflicted death at the prison since 2008.

KEY EVENTS

19. The man had served a number of prison sentences throughout his adult life. His prison records indicate that he was frequently found guilty of disciplinary offences in prison, including misusing drugs, possessing unauthorised items, using aggressive and abusive behaviour and damaging prison property. He often got into debt with other prisoners.
20. The man had often been supported through ACCT suicide and self-harm prevention procedures, usually when he self-harmed by making superficial cuts. In December 2013, he said that he cut himself as a means of coping.
21. In August 2012, the man was conditionally released from a three-year prison sentence. On 24 January 2013, he was recalled to HMP Preston, charged with further offences. On 4 April, he was convicted of robbery and theft. His sentence was four years and eight months in prison with a conditional release date of 12 June 2016.
22. Most of the man's victims were elderly women and the local press published the details of his offences. He told officers that this had led to other prisoners threatening him. Staff took appropriate action to protect him. On 4 July, he moved to HMP Stoke Heath.
23. On 15 December, the man told a nurse that he had cut his thighs two days earlier as he was worried about his father who had heart problems and cancer and lived alone. He said that self-harm was the way he dealt with stress. She began ACCT procedures but described the injuries as "superficial scratches". No treatment was necessary.
24. The next morning, at an ACCT assessment interview, the man told an officer that he harmed himself as a way of dealing with stress and he had no intention of killing himself. An ACCT case review assessed his level of risk as low and ACCT monitoring continued until 2 January 2014. By this time, his father was in a care home and the man said that he felt better as a result.
25. The man's records contained many reports and security alerts about him using illegal drugs, suspicions that he was involved in trading prescribed medication and associated disciplinary offences. On 10 March, he told a substance misuse doctor that he had been using illegal drugs and taking medication prescribed for other prisoners. He asked to begin a detoxification programme. The doctor prescribed lofexidine to treat symptoms of withdrawal from opiate drugs.
26. On the evening of 10 March, the man told an officer that several prisoners had indecently assaulted him two hours earlier. He thought that they had believed he had drugs hidden in his rectum. The officer informed a supervising officer who immediately informed healthcare staff and the police.
27. A nurse spoke to the man and advised him not to wash until the police had seen him. He told the nurse that he would harm himself or "string up" (hang himself) because of the incident and she began ACCT procedures to support him. Officers took him to the segregation unit for his own safety.

28. Police detectives arrived an hour later and asked nurses to examine the man for injuries. A nurse noted that he had superficial scratches to his lower back but there were no other visible physical injuries. (We understand that the police investigation into the alleged assault was ongoing at the time of the man's death.)
29. At part of the ACCT procedures, staff checked the man twice every hour during the night. At an ACCT assessment interview the next morning, he said he was feeling shocked and unsafe because of what had happened the previous evening. He said that he had harmed himself previously when his father had been unwell and that his father was again unwell and in hospital. However, he said that he did not have any current thoughts of suicide or self-harm. His observations were adjusted to one every hour. A nurse saw him that afternoon and noted that staff were supporting him through ACCT procedures and the segregation unit officers were supportive. He told the duty chaplain that he was very upset but the segregation staff had been very kind.
30. At about 8.00am the next morning, 11 March, a doctor examined the man and noted that he looked shaken and complained of anal discomfort. She found injuries consistent with sexual assault and prescribed anusol cream and zopiclone, a sleeping tablet.
31. The man did not want to go back to a standard wing and said that he felt safe in the segregation unit. Staff arranged a transfer to HMP Featherstone and he moved on the afternoon of 13 March. At a health screen, when he arrived at Featherstone, the man reported a history of self-harm both in and out of prison. A nurse (the first nurse) noted the man had his prescribed medication which included mirtazapine, an antidepressant. Although his clinical record indicated that he had often misused prescribed medication, the first nurse noted that the man was suitable to keep medication in possession. The next day a prison GP re-prescribed mirtazapine.
32. The man should have had an initial ACCT case review within 24 hours of staff opening the ACCT plan, but this had not happened before he left Stoke Heath. A supervising officer (SO), a unit manager at Featherstone, held his initial review on the morning of 14 March accompanied by a wing officer. The SO noted that the man said he had had no thoughts of suicide or self-harm, but he was only just settling into his new surroundings. The SO wrote a care plan with two actions: for him to move to a prison closer to his home in north-west England and for him to continue to be treated for symptoms of depression. The SO noted that staff should have, and record, conversations with him three times during the day and he should be observed hourly at night and whenever he was locked in his cell.
33. A worker from the drug treatment team later saw the man and noted he would continue a lofexidine detoxification programme.
34. The man's offender supervisor, held the next ACCT case review on 17 March. No other staff attended. The man said that he was feeling much more settled but asked about mental health support and the offender supervisor referred him

to the mental health team. The man said that he found the number of night ACCT checks a little disruptive and the offender supervisor reduced the frequency from one an hour to three during the night. Staff were still expected to have three conversations with him during the day. The offender supervisor told the investigator that healthcare staff or someone from the chaplaincy team were usually asked to attend ACCT reviews but they were not always available.

35. A note in the man's records on 22 March stated that he was associating well with other prisoners and appeared to have no concerns. On 24 March, an SO held an ACCT review with him. There was no other member of staff present. He remained concerned about his father's health. The SO assessed the man's risk of suicide and self-harm as low and maintained the same frequency of observations as agreed on 17 March.
36. On 24 March, a drug treatment consultant saw the man and prescribed seven tablets of promethazine hydrochloride to help him sleep. He was allowed to keep the tablets in his possession.
37. On 26 March, the man told another doctor that he was still having trouble sleeping and he did not think that the promethazine hydrochloride was adequate. The doctor prescribed a seven day course of zopiclone. At interview, he recognised that zopiclone is addictive and can be traded by prisoners, but he was more concerned about the man's immediate need for sleep after the alleged assault. He prescribed the zopiclone tablets to keep in his possession.
38. On 28 March, another prisoner reported that his canteen (prison shop) order was missing. An officer checked CCTV records, which showed that the man had taken it. The officer and two other officers called him to the wing office and asked him what he had done with the canteen order but he refused to say. The man snatched his ACCT document from the desk, and began to rip the front cover. The officers restrained him and took him back to his cell.
39. The officer said the man struggled a little when he was initially restrained but he quickly calmed down. He asked the man again what he had done with the other prisoner's canteen order but he still refused to say. The officer checked the CCTV again and saw that he had taken the order to another prisoner's cell where he appeared to have shared it with several other prisoners. The officer submitted a security report.
40. On 30 March, a nurse checked the man's medication and found that he had no zopiclone when he should have had four days' supply left. She noted his clinical records that he should not be allowed any more medication in-possession.
41. On 31 March, another SO held an ACCT review. He was joined by a wing officer and noted that he had spoken by telephone to the nurse. The SO again assessed the man as at low risk of suicide and self-harm. He said that he had been able to speak to his father but he was still waiting to see someone from the mental health team. The SO arranged a mental health appointment for 9.30am the next morning. Staff were still required to check him and record their

observations in his ACCT document. The SO scheduled the next review for 7 April.

42. A chaplain saw the man later on the afternoon of 31 March and made a lengthy entry in his ACCT plan. The chaplain noted that the man was frustrated that he had still not seen a mental health nurse but had an appointment the next day. The chaplain added:

“... I am passing his name to the Chaplaincy Department ... to look to the possibility of counselling – as agreed with him. There is a real danger of him seeking to take his own life (I think). He spoke of hanging from the banister!! [sic] Need to be aware of this ...”

43. A third SO spoke to the man at 6.00pm that evening to discuss a forthcoming review of his security categorisation. He told the third SO that he wanted to transfer to another prison and they completed a transfer request. The third SO told him that a transfer could take some time, unless the Governor could arrange an individual exchange. The third SO told the investigator that he had read the chaplain’s comments in the ACCT document before speaking to him. He did not consider that he needed to hold an ACCT review, or that he should increase the frequency of observations, as he had been positive when he spoke to him.
44. On the morning of 1 April, the man went to the prison’s healthcare centre and asked to see the first nurse (who he had seen when he had first arrived at Featherstone, on 13 March). The first nurse was not aware that the man had an appointment but saw him anyway. The first nurse did not record his consultation with the man as a mental health assessment. The man said that other prisoners from his workshop had been asking why he moved from Stoke Heath and that he wanted to move to a different houseblock as the one he was on was too noisy. He said that he had been promised a move to a prison in a different area. He accepted that a transfer would take some time, but needed to know that something was being done about it. The man also said that his medication was due for review.
45. The man then handed the first nurse a strip of torn bed-sheet and said that if his problems were not resolved he would hang himself from the handrail above the stairwell. The first nurse told the investigator that, at the time, he did not believe that the man’s threats were genuine and he told him that his behaviour was inappropriate. The first nurse told the man that his antidepressant could soon be increased and he seemed happy about this.
46. The first nurse told the third SO what the man had said and he made detailed entries in his clinical records and in his ACCT document. The first nurse said that the third SO did not ask him to attend the ACCT review, which he held later that morning. The third SO told the investigator that after the first nurse had spoken to him he called the man to the wing office for an immediate ACCT review which one of the wing officers attended. The third SO asked him about the strip of material he had passed to the first nurse. The man told him he did not feel suicidal, but if he did, hanging would be the method he would choose. The third SO raised his observations to once an hour at night and once every

hour during the day. He arranged another ACCT review for the following day. He noted in his summary that he would speak to the Head of Residence and Safety, and noted on the ACCT caremap that the man had had an appointment with someone from the mental health team that morning.

47. Featherstone holds a multi-agency safer health (MASH) meeting every Wednesday to discuss all prisoners being managed under ACCT procedures and other prisoners who staff consider might be vulnerable. At the meeting on 2 April, the third SO said he was concerned about the man and arranged a multi-disciplinary ACCT review that afternoon. The Head of Residence and Safety's name was not on the list of attendees at the case review, but she said that she had chaired the review. Four other members of staff had attended: the third SO, the nurse, an officer from the safer custody team and an officer from the resettlement team. The Head of Residence and Safety said that the man had quite a few issues including the alleged sexual assault and that other prisoners who had transferred from Stoke Heath were asking him why he had transferred. He continued to be worried about his father's health and that he owed several ounces of tobacco to other prisoners.
48. At the review, the Head of Residence and Safety asked the man if other prisoners had threatened him but he said this was not the case. She arranged for him to buy additional tobacco to pay off his debt to other prisoners. They discussed the possibility of a move to a new prison and she said she would look into this. No new actions were added to the man's caremap but she took responsibility for dealing with his transfer to a new prison.
49. The Head of Residence and Safety told the investigator that while the man had a number of problems, none of them was insurmountable. She could not recall him asking to move to the segregation unit and said that if he had asked, she would not have agreed as he said he had said he was not under any specific threat and they had worked out a plan to pay off his debts. The third SO said that the man had seemed quite upbeat and had responded positively to the proposals for dealing with his concerns.
50. A nurse attended the review and said that she thought that the man's biggest concern was his tobacco debt. She said that she understood that he had owed only four ounces, which was negligible compared to many prisoners. She did not think that he presented as a person at particular risk of suicide. She noted in his clinical records that he had a mental health review booked with the nurse on 7 April.
51. At 6.45pm on 2 April, an officer wrote in the man's ACCT to say that he had been out and about on the wing, but staff should monitor him for any signs he might be being bullied. The officer told the investigator that he had not observed any incidents of bullying but he had wondered whether other prisoners had pressured him or suggested to him that he should steal the other prisoner's canteen order, which they would all then share. He therefore thought it was worth highlighting the need for staff to monitor the situation.
52. One of the prisoner violence reduction representatives told the investigator that, on the afternoon of 3 April, an officer had asked him to speak to the man as he

was on an ACCT. (Violence reduction representatives are prisoners who help stop and reduce bullying and conflict between prisoners.) The man told him that his father was terminally ill and the rest of his family had turned against him. His family did not want him to visit his father in hospital and did not want him to attend the funeral when he died. The violence reduction representative said that the man was calm and said that he only needed a few days “to get his head together”. He did not mention the assault at Stoke Heath. He did not speak to the man specifically about whether he was in debt at Featherstone, as no one had asked him to do so and the man did not mention this as a concern. The violence reduction representative told the investigator that he saw nothing to indicate that the man was about to harm himself.

53. The fourth SO told the investigator that he had had no dealings with the man before 3 April. When he checked the ACCT documents that morning, he saw that the man had had a multi-disciplinary ACCT review the previous day when the Head of Residence and Safety had suggested a way for him to pay off his debt. He spoke to her to find out more and she asked him to speak to the man to let him know what the prison was doing to deal with his problems. The fourth SO also spoke to the nurse, who said that the man’s main problem at that time was his tobacco debt. The fourth SO then spoke to the man at about 3.45pm that afternoon. He said that his problems were the same as discussed at the ACCT review the previous day. He said that he owed four ounces of tobacco, but he would be able to pay that off when he got his canteen order the next day. The fourth SO said that they spoke for around 15 minutes and that he appeared fine and light hearted.
54. During the conversation, the fourth SO asked the man if there was anything else he wanted to discuss. He said that the man had asked when he would be moving to the segregation unit. (Prisoners can be segregated for their own protection if they are at risk from other prisoners, usually if there are no other options to keep them safe.) The fourth SO told him that that was not part of his action plan and there were other options if he felt unsafe on the wing. He then ran out of the wing office and climbed over the banister above the stairwell (with a drop of around three metres to the stairs below). The fourth SO and two officers grabbed him and pulled him back over the banister rail. He began to struggle so the officers restrained him to take him back to his cell. By the time they reached the cell, they said that he had calmed down and they no longer needed to restrain him.
55. Shortly afterwards, a nurse went to see the man to check whether he had any injuries (this is required when a prisoner has been physically restrained). He said he had no injuries, but he would not let her examine him. She noted that he had been abusive and aggressive.
56. The nurse recorded just before 5.00pm that the man did not get his antidepressant medication (mirtazapine) that afternoon as she had decided that it was not safe for him to come to the medication hatch, because of his earlier aggressive behaviour. She told the investigator that mirtazapine was a slow release medication so missing one dose would not have any affect on the patient. She said that nurses did not take medication to prisoners’ cells unless they were in the segregation unit.

57. At 6.00pm, one of the officers who had helped pull the man back over the banisters that afternoon and escorted him back to his cell, noted in his ACCT document entry that the man was lying on his bed watching television and that there were no further concerns. No one held an ACCT case review after he had tried to jump over the banister to reassess his level of risk and to establish whether he needed further support.
58. At around 7.15pm on 3 April, an officer was checking that all prisoners were present on the wing. When he reached the man's cell, he told the officer that he had not had his afternoon medication. The officer went to the wing office to find out why. Another officer telephoned the healthcare centre and a nurse told him that the man would not be having medication that day but would get it the next day. Both officers went back to his cell to tell him. They said that he appeared to accept this.
59. At 8.45pm, the officer handed over to two operational support grades responsible for patrolling the wing that night. They checked the man at 8.30pm, and continued to check him each hour into the early hours of 4 April. At 2.45am, the man was sitting on the bed watching television. The man looked up, smiled and put his thumbs up.
60. A prisoner who was in the cell next to the man, told the investigator that he had only talked to the man a little and had given him some tobacco. He said that at about 8.30pm on 3 April, they had spoken a little through the pipe ducting between the cells, but not about anything important and the man did not say anything unusual, or which caused the prisoner concern. He had asked for a little more tobacco, which the prisoner passed to him some through a little gap in the ducting. At about 3.00am, the prisoner heard the pipes rock and thought that the man might be bored and trying to attract his attention. He banged the pipe in reply but he heard no more sounds from the man's cell. The next thing he heard was when prison staff went into the cell 45 minutes later.
61. When one of the support grade staff checked the man at 3.45am the television was on and provided some light in the cell. The bed frame was lifted on end and leaning against the far wall. The man was lying on his side on the floor. The support grade switched on the cell light and kicked the door to try to attract the man's attention. He did not stir and the support grade could not see his chest moving. He radioed a code blue alarm, used to indicate a life-threatening situation such as when a prisoner has serious breathing problems, is unconscious or hanging. The other support grade ran to the cell and saw the man on the floor. He thought that the man appeared dead and he radioed the night orderly officer, who was in charge of the operation of the prison that night. He asked for permission to go into the cell, but the night orderly officer said he was on his way and asked him to wait until he got there.
62. The night orderly officer got to the cell in around two minutes. He told the investigator that when he looked through the observation panel he saw the man on the floor with a cord around his neck. When he unlocked the door and went in, he said it was clear to him that the man was already dead. His eyes were wide open and bulging and he had no colour. The cord was from a prisoner

identification card, which prisoners wear around their necks. He cut the cord away and checked the neck for a pulse. He could find no signs of life and his skin was cold to the touch.

63. The orderly officer told the investigator that he was a qualified first-aid instructor and had previous experience of dealing with deaths in his previous police career and as a first aid volunteer at football grounds. He said it was clear that the man was dead so he did not attempt to resuscitate him. Instead, he locked the cell until paramedics arrived. (There are no healthcare staff on duty in the prison at night.)
64. The control room did not call an emergency ambulance when the code blue alarm was first raised, but waited until the night orderly officer requested one, five minutes later. A rapid response paramedic arrived at 4.04am. The paramedic checked the man and noted that his pupils were fixed and dilated. An electrocardiogram indicated that there was no electrical activity in the heart. The paramedic did not administer any emergency treatment and at 4.20am, pronounced him dead.
65. The man had written messages which he had pinned to his cell notice board explaining that he had decided to take his life. These indicated that he thought that the prison had not given him the help and support he needed.
66. The man had named his mother as next-of-kin. She lived in Lancashire, some distance from Featherstone and the prison contacted the local police and asked them to inform her of her son's death. Featherstone considered that this would be the quickest way to inform her. They did not ask a nearby prison to do this as Prison Service instructions expect. When the police arrived at her home she was not there. Neighbours told them that they understood that both of the man's parents were in care homes.
67. Featherstone located the home where the man's father was a resident, but they explained that he was very ill and would probably not understand. The home gave contact details for the man's brother, who lived near Featherstone. The Governor and one of the prison's managers went to his home at around midday. He was at work, but they told his partner what had happened and she said she would let the man's brother know when he got back from work. At around 4.30pm the man's brother telephoned the manager, who gave him more information about his brother's death. The man's brother said that his mother was in a care home somewhere in the Preston area but he did not know any more than that. Later that afternoon Featherstone found out where she was a resident and the Governor and manager visited and spoke to her in person.
68. Featherstone paid the funeral costs in line with Prison Service national policy.
69. The cause of death was given as hanging. The pathologist explained that it seemed that the man had hanged himself from his bed frame but the ligature had broken away causing him to fall to the floor. Toxicological screening for a range of drugs found none present in his system.

ISSUES

Clinical care

70. The clinical reviewer was satisfied that the man received appropriate treatment and care from Featherstone's drug treatment team for his ongoing substance misuse problems. She was critical of some aspects of his care, including the standard of clinical record keeping and risk assessments for in-possession medication. She has made some recommendations that the Head of Healthcare will need to address but we have not repeated here as they were not directly related to the circumstances of his death.
71. We are concerned that there appeared to be some confusion about the man's mental health appointment on 1 April. He had asked about mental health support at an ACCT review on 17 March and the third SO referred him to the mental health team. (There was no member of the healthcare team at the ACCT review.) On 31 March at another ACCT review, he said he had still not seen anyone from the mental health team and the third SO arranged an appointment for 9.30am the next morning.
72. Although the first nurse spoke to the man in detail about his current thoughts and situation on the morning of 1 April, the clinical reviewer found that this was not a formal primary care mental health assessment. Whatever the reasons for the lack of clarity about the referral we are concerned that it is evident that a prisoner who had been identified as at risk of suicide and self-harm and had recently been the alleged victim of a violent sexual attack had not been prioritised for a mental health assessment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.

ACCT procedures at Stoke Heath

73. A nurse at Stoke Heath opened an ACCT for the man at 8.20pm on 10 March. Prison Service Instruction (PSI) 64/2011 which governs ACCT procedures requires a first ACCT case review to be held within 24 hours of the ACCT being opened. The first review should have been held on 11 March, ideally with the person who had assessed him present, and others who knew him and the background to the issues that had led to the ACCT being opened. There had been no ACCT review before he transferred to Featherstone on the afternoon of 13 March, three days after the ACCT had been opened. The first review was held at Featherstone on 14 March. Stoke Heath was unable to explain this omission. We make the following recommendation:

The Governor of HMP Stoke Heath should ensure that initial ACCT case reviews are held within the required timeframe.

ACCT procedures at Featherstone

74. The man had six ACCT case reviews at Featherstone chaired by five different managers. We are concerned at the lack of consistency of case management and that few reviews were multidisciplinary attendance at reviews. In two cases just one member of staff held a review. A nurse attended two reviews but there was no one from the healthcare team at the other four. An SO said that healthcare staff were not always available to attend reviews. However, the first nurse said that he was not asked if he could attend the review on 1 April, although he had seen the man earlier that morning and had been concerned about him.
75. PSI 64/2011 requires ACCT case reviews to be multidisciplinary where possible and involve key people who know the person at risk or who are involved in their care. It is mandatory that a member of healthcare staff attend at least the first ACCT case review. This did not happen and where there are ongoing healthcare issues, particularly relating to mental health, we would expect consistent healthcare attendance at further reviews. Whether or not reviews are multidisciplinary, it is implicit that ACCT reviews, which are based on teamwork, are not held by just one member of staff. This is poor practice.
76. On 3 April, the man appeared to think he would be moving to the segregation unit. It is not clear why he thought this. It had not been discussed at his ACCT review the previous day, was not a caremap action and there is no evidence that other prisoners were threatening him. When the fourth SO told him that he was not being moved to the segregation unit, he ran from the office and climbed over the stair banisters. He had to be pulled back onto the landing and restrained before being taken back to his cell. We do not know the motive for this, but it is possible that he believed that a threat to jump down the stair well would force staff into moving him to the segregation unit. Whatever the motive, we are concerned that there was no ACCT review at that stage, to review his risk and support plan. An ACCT review would have allowed staff to question his intentions when he threatened to jump and discuss what needed to be done to keep him safe, including reviewing the level of required ACCT observations.
77. Many of the man's night-time observations at Featherstone were at precise and regular intervals. On the night of his death the staff checked him at 9.45pm, 10.45pm, 11.45pm, 00.45am, 1.45am, 2.45am and 3.45am. CCTV records indicate that these times were accurate within a minute or two. There were similarly timed checks the previous night. ACCT observations should be made at unpredictable intervals so that prisoners cannot be sure when the next check will be made.
78. We understand that the man was impulsive and had a long history of minor self-harm. His behaviour during his final days was similar in many respects to his previous behaviour. However, he had been identified as at risk of suicide and self-harm and it is important that prisons follow the specified procedures to protect prisoners at risk. The investigation has identified a number of deficiencies in ACCT procedures and we make the following recommendation:

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

- **Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner's care;**
- **Conducting an ACCT review whenever there is a clear sign that risk has increased;**
- **Considering all known risk factors when determining the level of risk of self-harm and considering all potential trigger factors;**
- **Ensuring continuity of case manager whenever possible; and**
- **Carrying out ACCT observations at irregular intervals to prevent prisoners being able to predict when they will take place.**

Emergency response

79. When the support grade staff found the man lying on the floor of his cell he called other support grade for help. He told the investigator that he was nervous about going into the cell as he had previously done so and the prisoner had then sat up. In contrast, the other support grade said that it seemed clear to him that the man was dead, but when he radioed the night orderly officer, he told him he was on his way and to wait until he arrived before he opened the cell.
80. At night staff on wings do not carry standard keys, but have a cell key in a sealed pouch for use in an emergency. National instructions in PSI 24/2011 say that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger and should first make every effort to get a verbal response from the prisoner. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment of the situation.
81. The support grade staff gave contrasting accounts of what they saw when they looked into the cell. As one of them called an emergency code blue he had already assessed the situation as life threatening. Both he and his colleague knew that the man was regarded as at risk of suicide and self-harm. While we understand that it is difficult for staff in such situations to make immediate decisions, when someone is in a potentially life threatening situation, it is essential to act quickly. In such circumstances we would normally expect staff to go into a cell as soon as possible, in case there is a chance of saving someone's life. As there were two members of staff present, we would have expected them to have gone in immediately. We would not have expected the night orderly officer to instruct them to wait. We make the following recommendation:

The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life.

82. The night orderly officer told the investigator that the man had no pulse and it was clear to him from his appearance that he was dead. The night orderly officer said that he had reasonably extensive experience of dealing with death. He said that he thought he had made the right decision in not attempting resuscitation. We understand his decision, which seems to have been appropriate on this occasion, but Featherstone's local contingency plans state that staff should give appropriate first aid until qualified help arrives. Unless there is clear evidence, such as the presence of rigor mortis, that it would be futile to attempt resuscitation, we consider that it would be safer to do so.
83. We are concerned that there was a five minute delay before an emergency ambulance was requested. The officer who was working in the control room that night told the investigator that at the time of the man's death the procedure with a code blue alarm at night was that the night orderly officer would first confirm the nature of the emergency before deciding whether an ambulance was needed. This is what happened.
84. Prison Service Instruction 3/2013 (issued February 2013) requires that governors must have a medical emergency response code protocol to ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The officer said that he followed what he believed to be the correct procedure in waiting for the night orderly to confirm the nature of the emergency. However, in investigations into two deaths at Featherstone in 2013 we also found that staff did not call an ambulance immediately. We made recommendations which the prison accepted and said that they had implemented. It is unacceptable that there are still delays at Featherstone in calling emergency ambulances. We make the following recommendation:

The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff:

- **Initiate basic life support until qualified health professionals arrive, unless there are clear signs of death such as the presence of rigor mortis.**
- **Call an ambulance as soon as a code blue alarm is made.**

RECOMMENDATIONS

To HMP Stoke Heath

1. The Governor of HMP Stoke Heath should ensure that initial ACCT case reviews are held within the required timeframe.

To HMP Featherstone

2. The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.
3. The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner's care;
 - Conducting an ACCT review whenever there is a clear sign that risk has increased;
 - Considering all known risk factors when determining the level of risk of self-harm and considering all potential trigger factors;
 - Ensuring continuity of case manager whenever possible; and
 - Carrying out ACCT observations at irregular intervals to prevent prisoners being able to predict when they will take place.
4. The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life.
5. The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff:
 - Initiate basic life support until qualified health professionals arrive, unless there are clear signs of death such as the presence of rigor mortis.
 - Call an ambulance as soon as a code blue alarm is made.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<u>To HMP Stoke Heath</u> The Governor of HMP Stoke Heath should ensure that initial ACCT case reviews are held within the required timeframe.	Accepted	All staff who conduct ACCT case reviews were reminded in July 2014 via individual e-mails and through a Notice to Staff of the need to conduct reviews within nationally set timescales under PSI 64/2011. Compliance for this is monitored daily by the safer custody team	Completed Head of Safer Custody	
2	The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment	Accepted	A Governor's Operational Order was published 31/11/14 and has been circulated to all staff. Since October 2014, it has been a standing agenda item at weekly Multi Agency Safer Health meetings that prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment. This will ensure mental health referrals are followed up by Primary Mental Health in a timely manner. Healthcare will ensure all prisoners who arrive and are identified at risk of suicide and self harm are to be referred for a mental health assessment immediately. This will be carried out at the reception screening based on what the prisoner reports, and any available risk information and previous concerns of self-harm or suicide from previous establishments.	Complete Head of Safer Custody Complete Head of Healthcare	
3	The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: <ul style="list-style-type: none"> • Holding multidisciplinary case reviews attended by all relevant 	Accepted	Governor's Operational Order 014-2014 was published in April 2014 and republished in October 2014 to ensure all staff are aware: - that all reviews should be multidisciplinary and at least include a member of Healthcare or Healthcare report	Complete Head of Safer Custody	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<p>might read better above with all the information about training].</p> <p>It is anticipated that 100% of staff will be refresher trained in the ACCT process by July 2015</p> <p>A pocket guide to ACCT procedures was issued with November's payslips to all staff.</p>	<p>Target date for completion: 31/7/15 Head of Safer Custody</p> <p>Complete Head of Safer Custody</p>	
4	The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life.	Accepted	<p>A Governor's Order was published on 31/10/14 to ensure staff understand factors to consider during a personal risk assessment. This has now been circulated to all staff.</p> <p>Local Security Strategy was amended in November 2014 providing a hyperlink to the new Governor's Order which staff can access for reference.</p> <p>It has been reiterated to all night staff, via e-mail that subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life.</p>	<p>Complete Head of Safer Custody</p> <p>Complete Head of Security</p> <p>Complete Head of Security</p>	
5	The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies,	Accepted	A Governor's Order was published in October 2014 to remind staff of the importance of initiating basic life support until health professionals arrive. This has been reiterated to all Night Orderly Officers.	Complete Head of Safer Custody	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<p>including that staff:</p> <ul style="list-style-type: none"> • Initiate basic life support until qualified health professionals arrive, unless there are clear signs of death such as the presence of rigor mortis. • Call an ambulance as soon as a code blue alarm is made. 		<p>A Governor's Operational Order, 046-2013 was published on 11 December 2013 setting out With regards to the Code Blue and Code Red emergency procedures. Notices have been displayed in the Control Room to reinforce this. A more recent Governor's Order regarding Code Red & Code Blue procedures was republished in October 2014 and circulated to all staff.</p> <p>First Aid Training was reviewed in November 2014. An appropriate number of staff have received training: all Custodial Managers are trained in basic first aid, and there is always a Custodial Manager on duty at any point (including nights) as first response to any emergency.</p> <p>All recommendations and actions on the above action plan will be reviewed monthly at the Safer Custody meetings as a standing agenda item</p>	<p>Complete Security Custodial Manager</p> <p>Complete Head of Safer Custody</p> <p>Complete Head of Corporate Services</p>	