



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a prisoner at HMP and
YOI Moorland on 10 February 2014**

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 prisoner who was found hanged in his cell at HMP Moorland on 10 February 2014. He was 34 years old. I offer my condolences to the man's family and friends.

The investigation was conducted by a senior investigator. A doctor reviewed the clinical care the man received in prison. HMP Moorland cooperated fully with the investigation.

The man had been in prison since 2009 and moved to Moorland in 2011. In December 2013, the man told staff he was being bullied at work, but would not identify anyone responsible. Prison staff were unable to find any evidence that he was being bullied. He was referred to mental health services on 17 January 2014 after officers became concerned about him. Two days later, on 19 January, an officer opened suicide and self-harm prevention procedures after the man reported suicidal thoughts and harmed himself. From 20 January, the man was constantly supervised for eleven days as he was regarded as at high risk of suicide. At a case review on 31 January, his level of observations was reduced to hourly, although his risk was still assessed as high. Just a week after he had been constantly supervised, his observations were reduced further to three times during the day and he was assessed as a low risk. Three days later, an officer unlocking cells after lunch found the man hanging. Staff and paramedics were unable to resuscitate him.

The clinical reviewer found that the man received an appropriate standard of mental healthcare at the prison and, overall, I consider that Moorland provided some good supportive care. However, there were some procedural difficulties with managing the suicide and self-harm prevention procedures which the prison needs to improve, including the need for multi-disciplinary case reviews involving mental health staff when prisoners are under their care. While I recognise it would have been difficult to predict the man's actions on 10 February, I am concerned that the required frequency of observations appears to have been reduced very quickly after the man's lengthy period of constant supervision.

The 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

October 2014

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SUMMARY

1. The man was remanded to HMP Doncaster on 31 October 2009. This was his first time in prison. On 1 June 2010, he was sentenced to seven years imprisonment. On 14 December 2011, he moved to HMP and YOI Moorland.
2. On 10 December 2013, the man asked to be moved from his job in a prison workshop as he said he was being bullied. However, he did not want to complete a formal bullying statement indentifying who was responsible and officers could not find any evidence that he was being bullied.
3. An officer opened suicide and self-harm support procedures (known as ACCT) on 19 January 2014 after the man tried to hang himself and made cuts to his arms. He was taken to hospital later that day after he said that he had also taken an overdose of paracetamol. He was managed under ACCT procedures until his death. On 20 January, his first ACCT case review, agreed he should be observed four times an hour. At a second review later that day, officers decided that the man should be constantly supervised and he moved to a cell in the prison's induction unit. On 28 January, a psychiatrist reviewed the man, but a doctor did not assess him again during the period he was constantly supervised. The man received frequent mental health intervention, but a member of the mental health in-reach team attended only five of his 11 case reviews.
4. On 30 January, the man told a prison chaplain that he had been bullied while living on his previous unit, Houseblock 3. At an ACCT review on 31 January, the case review decided to end constant supervision and reduced his level of observation to once an hour when he was in his cell. His level of risk of suicide and self-harm was still assessed as high. On 4 February, the case review decided that the man could return to his cell on Houseblock 3, which he wanted to do. On 7 February, an ACCT case review assessed his risk as low and reduced the frequency of observations to one in the morning, one in the afternoon, one in the evening and three at night.
5. At around 1.35pm on 10 February, an officer found the man hanging in his cell. Another officer telephoned the control room to notify an emergency. The control room staff asked for clarification, rather than calling an ambulance immediately, which led to a slight delay. Officers and healthcare staff attempted to resuscitate the man until paramedics arrived at around 2.00pm. At 2.33pm, a prison doctor pronounced the man dead.
6. We consider that the man received some good supportive care from staff at Moorland and the clinical reviewer considered that the standard of care the man received at Moorland was equivalent to that he could have expected to receive in the community. However the investigation identified some procedural flaws. Not all ACCT reviews were multi-disciplinary and we consider that someone from the mental health team should have been involved in all decisions about the man's care. We are not satisfied that the level of observations always reflected the man's assessed level of risk of suicide and self-harm and a prison doctor did not see the man while he was

subject to constant supervision, as should have happened. When the man was found hanging, control room staff did not call an ambulance immediately they were notified of the emergency.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Moorland announcing the investigation and asking anyone who had relevant information to contact him. No one responded.
8. NHS England commissioned a doctor to review the man's clinical care in prison.
9. The investigator visited Moorland on 14 February and spoke to staff involved in the man's care. He visited the houseblock and saw the cell where the man had lived. The investigator obtained copies of the man's prison and medical records and interviewed staff and prisoners at Moorland. He gave the prison verbal feedback about the preliminary findings of the investigation and followed this up in writing. At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations at the end of this report.
10. We notified HM Coroner for South Yorkshire East District of the investigation who provided the results of the post-mortem examination. We have sent a copy of this report to the Coroner.
11. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to raise matters they wanted the investigation to consider. They asked us to consider whether the suicide watch was managed appropriately. They asked whether staff had noticed any changes in the man's behaviour which should have alerted them to the fact that something was wrong in the days leading up to his death as they had been told by other prisoners that he had become noticeably more isolated. The man had told his family that he was depressed and was hearing voices. His family asked whether he had informed staff of this and whether he received the appropriate support and medication for his mental health needs. The man's family received a copy of the draft report.

HMP and YOI MOORLAND

12. HMP and YOI Moorland is a Category C training prison in South Yorkshire. It holds up to 1000 adult and young adult men. Health services are commissioned by NHS England (Doncaster) and provided by Nottinghamshire Healthcare NHS Trust. Services cover primary care, mental health and substance misuse. There is no inpatient facility and no full time nursing cover.

HM Inspectorate of Prisons

13. The most recent inspection of Moorland, in December 2012, found that prisoners had good access to mental health services and those at risk of suicide and self-harm were well cared for. However, ACCT case review meetings were poorly attended and there was no consistency in case management. Inspectors repeated a previous recommendation about the need for multi-disciplinary case reviews.

Independent Monitoring Board

14. 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 2013 annual report, the IMB said that there had been progress in the provision of healthcare services, but some prisoners reported waiting too long to receive prescribed medication. In their previous annual report, the IMB had been concerned about staff bullying prisoners, mainly attributed to a few officers. The IMB noted that the Governor was addressing the problem. A member of the IMB now attended the monthly Safer Custody meeting, of which they had previously been unaware.

Previous deaths at Moorland

15. The previous self-inflicted death at Moorland was in 2007. There were no issues directly relevant to the circumstances of this investigation.

ACCT - Assessment, Care in Custody and Teamwork

16. 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 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, and a review should be held within a week of the ACCT being closed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

17. On 31 October 2009, the man was remanded into custody charged with sexual offences against children. He arrived at HMP Doncaster that day. This was his first time in prison, and he asked to be treated as a vulnerable prisoner because of the nature of the charges against him.
18. On 1 June 2010, the man was convicted at Crown Court and was sentenced to seven years imprisonment. His mood after he was sentenced was recorded as low and he was prescribed mirtazapine (an antidepressant). He was last issued with this in October 2011). On 24 August, he transferred to HMP Shrewsbury.
19. On 11 December 2011, staff began Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures after he said that other prisoners were aware of his offences and had made threats to harm him. The ACCT was closed the next day.
20. On 14 December, the man transferred to HMP Moorland. At a health screen interview, he said that he had no thoughts of suicide or self-harm. There were no significant events recorded during 2012.
21. On 11 January 2013, a report prepared for a Parole Board hearing, assessed the man as a high risk of serious harm to children and known adults. On 13 March, the Parole Board refused the man parole as he had not undertaken any accredited work to reduce his risks.
22. On 1 March, a prison doctor prescribed the man amitriptyline (an antidepressant which is also used to treat migraines) as he said that he was having migraines which were affecting his sleep. The dose of amitriptyline was raised on 5 April and again on 9 August.
23. The man's offender supervisor told the investigator that the man believed that his sentence was too long. Although he had attended some offending behaviour courses, he refused to attend the sex offender treatment programme as he maintained that he was innocent. On 11 October, the man asked the offender supervisor if he could receive visits from some young relatives. The offender supervisor said that, because of his offence, he could not.
24. On 10 December, the man said that he was being bullied by other prisoners in his workshop because he was a quality controller. He declined to complete a formal statement about this because he said it would make the situation worse. The workshop supervisor recorded in the man's prison record that he was tearful so she sent him back to the houseblock. The workshop supervisor noted that the man was one of the best workers in the workshop.
25. On 13 December, the violence reduction officer spoke to the man about his allegations that he was being bullied. The man said he was under threat at Moorland. However, he would not submit a statement, give names or explain

why he felt threatened. The violence reduction officer decided that the man should not attend work until he had completed an investigation. When interviewed he said that he did not think that the man was at risk of suicide or self-harm. On 18 December, the violence reduction officer wrote in the man's prison record that he had completed his investigation and had not found any evidence to support the man's claims. Staff in the workshop and the man's houseblock had not corroborated his claims. The man was given a job as a cleaner on the houseblock and staff were asked to inform the violence reduction officer of any signs that the man was being bullied or threatened.

26. On 17 January 2014, an officer referred the man to the mental health in-reach team after prisoners and officers raised concerns about him. The officer wrote that the man seemed to be paranoid, losing weight and not associating with his friends as he had previously. He was pacing up and down on the landing. The primary mental health team arranged to see the man on 20 January. The offender supervisor spoke to the man that morning as she was concerned about his demeanour and wanted to find out what was worrying him. The man said that prisoners who lived in his local area were now at Moorland and they knew about his offences. The offender supervisor also contacted the man's offender manager to inform her.
27. During the afternoon of 19 January, an ACCT was opened after the man said that he had had thoughts of killing himself and had cut his arms the previous evening, at around 10.00pm. The man said that he had also tried to hang himself, and purple bruising was visible on the side of his neck. The man also said he had taken approximately 20 paracetamol tablets. Nurse A spoke to the National Poisons Information Service which advised that the man should be taken to hospital. He was taken to the local hospital.
28. Senior Officer B completed an ACCT immediate action plan. The plan was for the man to be located in a single cell, to be observed four times an hour until he was assessed and to be given access to Listeners and a telephone to speak to his family or the Samaritans. (Listeners are prisoners trained by Samaritans to offer support to other prisoners in distress.)
29. The man said that he had smashed his head on cell furniture before he had tried to hang himself and as he did not have the courage to cut himself deeply, he had taken a large amount of paracetamol. Senior Officer B arranged for the man to go to a care suite with Listeners when he returned from hospital. The man returned to Moorland later that day.
30. At an ACCT assessment interview on 20 January, the man said that he was worried about what would happen when he was released from prison (he was due to be released in June 2014) and also about being attacked by other prisoners because of his offence. At 10.00am, a custodial manager chaired the first ACCT case review. There was no one from the healthcare team present which is a mandatory requirement for the first ACCT case review. The man said that he did not have any thoughts of suicide or self-harm and the events of the previous day had been a blip. He wanted to continue as a cleaner and said he was looking forward to being released. Despite the

events of the previous day, his level of risk was recorded as low and the frequency of observations were reduced to one recorded conversation during the morning, afternoon and evening and three observations an hour during the night. No actions were recorded on the caremap.

31. A mental health nurse from the primary mental health care team, Nurse C, assessed the man after the first case review, but did not attend the review. The man said that people were talking about him, but there was no specific event which had triggered his self-harm. When pressed, he said that he was anxious about leaving prison. Nurse C recorded that the man appeared normal and relaxed, answered questions and did not appear paranoid.
32. Officer D spoke to the man at 10.25am, and noted in the ACCT document that the man felt much better and said he would speak to staff if he had any issues. Officer D noted at 12.00pm that the man was talking to staff and other prisoners. However, at 2.09pm, Office D recorded that the man appeared to have deteriorated since he had spoken to him earlier in the day. He said that the man appeared paranoid and thought he would be assaulted, although he had not received any threats. Officer D was unable to reassure the man. At around 2.40pm, Nurse C saw the man again at Officer D's request and found that the man was finding it difficult to say what was on his mind. He said that he was hearing voices telling him he was going to "get done in". The man said that he did not have any problems with anyone on the houseblock, but said he would feel safer on the induction wing. Nurse C advised against moving to the induction wing as it would mean that he would spend long periods alone in his cell and that it would not stop the voices.
33. Officer D contacted Nurse C again at 3.15pm because he was concerned about the man's risk of suicide and self-harm after he mentioned hearing voices in his head. They discussed whether constant supervision was appropriate. Nurse C agreed to support constant supervision because the man had not come into contact with the mental health team before and they knew little about him.
34. A residential manager chaired an ACCT case review at 3.30pm, attended by Officer D and a custodial manager. The man's level of risk of suicide and self-harm was reviewed and increased to high as he was very withdrawn and said he was hearing voices telling him to commit suicide. No one from the in-reach team attended this review. The case review decided that the man should be constantly supervised and he was moved to the induction unit to facilitate this.
35. Nurse C saw the man at 8.30am on 21 January. He recorded that although the man was hearing voices, he did not appear to be distracted by them during the consultation. The man was adamant that he wanted to remain on the induction unit. Nurse C noted in his medical record that there was a lack of evidence that the man was hearing voices (he thought that the man did not appear to be distressed by them) considered that his behaviour might be manipulative.

36. Prison Service Instruction 64/2011 gives instructions and guidance about constant supervision. When a prisoner is subject to constant supervision, a multi-disciplinary case management review must be held daily for the first 72 hours. It is then for the case review panel to decide the frequency of reviews after that. The safer custody manager held a review at 10.00am on 21 January, which was attended by Senior Officer B, the offender supervisor, Nurse C and a member of the chaplaincy team. Although the man engaged well, he was noted to be silent and withdrawn when he was asked if there were any underlying concerns about his offence and release from custody. His assessed level of risk of suicide and self-harm remained high and the man continued to be constantly supervised. The safer custody manager completed a care and management plan (Caremap). The goals were to:
- Engage with the mental health team.
 - Re-establish contact with his family (The man was given paper and a pen so he could write to them).
 - Write down and be honest about his concerns (The man did this and the note was passed to Nurse C).

The mental health teams discussed the man at their meeting later that morning. They decided that Nurse C would engage with the man until he saw a psychiatrist.

37. The safer custody manager chaired the fourth case review on 22 January. Nurse C, Senior Officer B, the offender supervisor and a member of chaplaincy also attended. The safer custody manager recorded that the man appeared more positive, but said that he had some reservations about being released. Another caremap action was listed, for the man to attend association on Houseblock 3. (Association is the period of time when prisoners are unlocked from their cells and can socialise with other prisoners.) There was no change to the level of risk or observations. Nurse C spoke to the man after the review and recorded that he was hearing two distinct voices (a female “voice of reason” and a male “evil” voice). The man said that he could not trust himself not to self-harm. Nurse C recorded that, despite the voices, he appeared totally relaxed and undistracted.
38. On the morning of 23 January, Nurse C saw the man, who said that things were worse. However, Nurse C wrote that the man appeared calm and there was no urgency when he declared how bad things were. A fifth case review was held later that day chaired by Principal Officer E, and attended by the offender supervisor, the Head of Residence and a member of the chaplaincy team. No one from the mental health team attended. There was no change to the level of risk or observations. Principal Officer E wrote that the man was in an “open state of crisis” and might self-harm.
39. The man gave Principal Officer E permission to contact his mother and the caremap was updated with this action. The man’s mother was upset but appreciative of Principal Officer E’s telephone call. Principal Officer E updated her about the man’s current state of mind and level of supervision. The man’s mother said she wanted to see him together with her ex-husband

and that other family members might also want to see him. Principal Officer E told her that the man was concerned that she would be angry at his current situation. Principal Officer E later told the man that his family were worried about him, but were not angry and wanted him to contact them. The man was allowed to call his mother from an office telephone in the presence of staff.

40. There was no change to level of risk or observations at the sixth case review on the morning of 25 January, which was attended by Senior Officer F, Principal Officer E and an officer. No one from the healthcare team attended. Principal Officer E wrote that the man was still felt low but had made good eye contact and contributed fully at the case review. The man told staff that if he was left alone he would harm himself again and “make a good go of it”.
41. On the morning of 27 January, Nurse C saw the man, who was painting his cell at that time. However, the man said that he was still hearing voices and, if he was left alone, would “do something”. Nurse C noted that there was no distress or emotion in the man’s voice and he appeared relaxed. At the seventh case review, held later that day, chaired by the safer custody manager and attended by Senior Officer F, The offender supervisor and a member of the chaplaincy team. His risk was still assessed as high and he remained constantly supervised. No one from the mental health team attended the review. The man said he had spoken to his father and his family were trying to book a visit. He agreed to continue to attend association on the houseblock, but still said he would cut himself. The caremap was updated with a new issue for him to reintegrate and an action recorded for the man to work as a cleaner on the houseblock.
42. On 28 January, a forensic psychiatrist, Dr G, saw the man. He would not talk about his offence, but said that he hoped to live with his parents when he was released. The man told her his problems had started a few months earlier when he had cut himself at work with a Stanley knife. He said that he had decided not to go to work again as he did not trust himself not to self-harm again. The man said that he had heard voices for the last two months (although the first time he mentioned voices to staff was on 20 January). He said that when he was on the houseblock the previous week he had thought of harming himself constantly, but since being constantly supervised his thoughts of hanging himself or cutting his wrists had reduced to about every two hours. The man described a good voice, which he recognised as his grandmother, which told him not to harm himself, and bad male voice which encouraged him to harm himself. He said the bad voice sometimes came out of the television even when the volume was turned down. The good voice had now gone and he was only hearing the bad voice. The man said he was also not sleeping well at night so he slept during the day. The man said he had cancelled a visit from his parents as he did not need their help.
43. Dr G decided to review the man in two weeks, and that he should be supported by the in-reach team in the interim. She prescribed an antidepressant, sertraline, and an antipsychotic, olanzapine. Dr G also arranged blood tests to check for any underlying conditions. (These were found to be normal.) Dr G later discussed the man with Dr H, a specialist

forensic psychiatrist who was her supervisor. Dr H told the investigator and clinical reviewer, that he did not have any concerns about Dr G's decisions or the support that the man had received.

44. When interviewed, Dr G said that she viewed the man's risk of harm as ongoing and not short term. However, she said that she did not expect him to take his own life and she had been reassured that he had talked about his plans for when he left custody and his confidence that he could keep himself safe.
45. In an e-mail of 28 January, Senior Officer F also informed several members of staff that the next review would be held on 29 January at 2.30pm. Nurse C replied that the man had now seen a psychiatrist, was under the care of the in-reach team and had been prescribed medication. Nurse C asked to attend further reviews "when required". The offender supervisor said that she had been in contact with his offender manager who had confirmed that the man would have a place at an approved premises (formerly known as a probation hostel) when he was released. She said that she had not shared this information with the man and would not do so until the time was right.
46. Senior Officer B chaired the eighth ACCT review on 29 January, attended by the safer custody manager, the offender supervisor and Nurse I from the mental health team. Senior Officer B recorded that the man was nervous about being in a normal environment. They discussed him starting work as a wing cleaner and using the gym again. After the review, Nurse I wrote in the medical record that, when she asked the man how he was feeling, he shook his head then placed it in his hands. Nurse I noted that when Senior Officer B made some light-hearted remarks, the man responded appropriately and, although the man did not seem to be in a low mood, he was reluctant to return to the houseblock.
47. On 30 January, Senior Officer F emailed staff to inform them that the man had told a member of the chaplaincy team that he had previously been bullied on Houseblock 3 because of his offence. Senior Officer F suggested that it might be worth moving him to Houseblock 4 when he left the induction unit.
48. The ninth case review was scheduled for 4 February, but the safer custody manager decided to hold a review on 31 January as he thought that the constant supervision was becoming intrusive and that it should not continue without a further review. (In the man's prison record, and in an email to other members of the ACCT review, the safer custody manager referred to this as an enhanced case review.) The case review still assessed the man's of risk of suicide or self-harm as high, but decided that the man should no longer be constantly supervised. However, he would remain on the induction wing and visit his houseblock during the core day. On the front of the ACCT document, the level of observations was set at hourly, but the safer custody manager wrote in the man's prison record that he should be observed every two hours during the day and hourly when he was locked in his cell. The man was adamant that he wanted to stay on Houseblock 3. There was no one from the in-reach team at the review. The safer custody manager recorded that they

had contributed “verbally”. When interviewed he said that he had spoken to Nurse I before the review.

49. Nurse I told the investigator that she had been unable to attend the review as she was dealing with a complex case for most of the day. Nurse I said that she did not recall giving any information for the ACCT review or being invited to attend.
50. The safer custody manager told the investigator that he had been concerned about the man remaining on constant supervision for longer than necessary as the process can become intrusive and detrimental for the prisoner. The safer custody manager said that the man had progressed from when he had first saw him and when the decision to stop constant supervision was made, he seemed stronger and healthier and was engaging positively. The man spoke about the future and a possible job opportunity after his release from prison.
51. According to PSI 64/2011, a doctor should see a prisoner on constant supervision at least once in every 24 hour period. Other than Dr G’s psychiatric assessment on 28 January, the man did not see a doctor at any time while he was on constant supervision.
52. At the tenth case review on 4 February, chaired by Senior Officer F, there was no change to the level of risk (which was not recorded) or observations. Senior Officer B and Nurse I attended. The record notes that the offender supervisor contributed. The man again said he wanted to return to Houseblock 3 as he had friends there. Senior Officer F recorded that the man said that he had thoughts of self-harm, but had not acted on them and was coping better. After the review, Nurse I recorded in the medical records that the man appeared calm and relaxed and spoke positively about his future. He moved back to Houseblock 3 that day at around 2.30pm.
53. Mr J, another prisoner, told the investigator that the man still seemed withdrawn when he returned to the houseblock. He told Mr J that he was in a “deep, dark place”. Mr J said that the man often used this phrase when anyone asked how he was.
54. On 5 February, Nurse I assessed the man’s mental health. She recorded in the medical record that he was cleaning the wing when she arrived, and smiled and presented well during the assessment, although he initially complained of having a headache. The man said that he still had thoughts of self-harm, but did not intend to act upon them. He said that had suffered from paranoia since he was 17, when he first began to hear voices. Nurse I noted that the man was very vague about this. He said the voices subsided, but the paranoia remained and worsened. The man said he had suffered from bouts of depression and when this was bad he felt he had nothing to live for. He said that the voices had recently returned, but were not currently a problem as he was able to resist their suggestions to self-harm. The man said he was nervous about his forthcoming release from prison in June and how his local community might react to his offence.

55. At the eleventh case review on 7 February, his level of risk was assessed as low and the frequency of observations were reduced to one in the morning, afternoon and evening and three during the night. Senior Officer B, who chaired the case review, recorded that the man appeared happier than he had been in the previous week. The man said he had no thoughts of self-harm and was managing his low moods by interacting with staff and keeping himself busy cleaning. Senior Officer B wrote on the prison record that he had reduced the observations with the view to closing the ACCT supervision after the next case review if the man continued to progress. Nurse I and the offender supervisor attended this review.
56. Nurse I wrote in his medical record that the man was initially subdued at the case review, but became more engaged and laughed and joked with the others. He said that he had continued to find prison stressful and was coping better, but at times he still locked himself away from others. When interviewed, Nurse I said the man was bright and cheery at the review.
57. On the morning of 8 February, a note in the ACCT ongoing record said that the man said he was okay, but felt alienated from other prisoners. He collected his lunch at 11.30am and no problems were recorded during association after lunch. At 5.40pm, it was recorded that the man was on his bed in the dark. His television was on, but he was not watching it.
58. At around 7.25am on 9 February, it was recorded in the ACCT ongoing record that the man was on his bed smoking and watching television. At around 10.00am, he said that he felt okay, but still felt threatened on the landing although he did not know who by. At lunch time, Officer K checked the man at around 12.30pm. Officer K recorded that when he opened the observation flap to check on the man he put his thumb up. This was the first time they had met. At 3.00pm, the man said he was fine, but still felt cautious when he went out his cell. At 6.00pm, it was recorded that he was lying on his bed watching television. Overnight, officers recorded checks at 8.30pm, 1.20am, 5.20am and 7.25am and noted he was asleep.

10 February 2014

59. At 9.30am on 10 February, Officer L recorded in the ACCT record that the man was cleaning and seemed in good spirits. When interviewed, Mr J said that the man had come to his cell for a cigarette that morning. Later, Mr J went back to his cell and found that the man had left a box of cereal on his bed. He went to the man's cell and gave him a packet of crisps in return. The man thanked him. This was the last time Mr J saw him. He told the investigator that there was nothing in the man's behaviour that morning which suggested he might harm himself. Mr J said if he had thought that the man might self-harm, he would have spoken to prison staff to warn them.
60. At around 12.30pm, during lunch time, Officer K checked the man. He opened the cell observation flap and saw him on his bed. Officer K asked if he was okay and the man raised his hand in response.

61. At around 1.35pm, Officer M and Officer L began to unlock the second landing of A wing on Houseblock 3. In his statement, Officer M said that, when he unlocked the man's cell, he found him hanging from his cell window bars by a ligature made from his bed sheet. He shouted to Officer L that they had a code blue (an emergency code indicating that someone is not breathing or is unconscious). As he did not have a radio, Officer L ran to the wing office (which was about ten feet away) and telephoned the control room to inform them of a code blue emergency. Officer L also told Senior Officer B what was happening and returned to assist Officer M.
62. Officer M supported the man with one arm and decided to cut the ligature with the other. In a statement afterwards, he said he had been surprised by the man's weight and the man's head had hit the table as he lowered him to the floor. Officer M removed the ligature from around the man's neck and checked for a pulse. Officer M told the investigator that the man's eyes were dilated, he was warm and there was some blood coming out of the corner of his mouth. Officer M was sure that he could feel a pulse.
63. According to the communications room log, the code blue message was received by telephone at 1.36pm. Senior Officer B repeated the message by radio at 1.37pm. Control room staff then asked whether an ambulance was required and Senior Officer B confirmed that one was. An ambulance was called at 1.38pm.
64. Officer M and Officer L put the man into the recovery position and made sure his airways were clear. Nurse A arrived and they moved the man onto his back to start cardiopulmonary resuscitation. Nurse A checked that the man's airway was clear. Nurse N arrived at 1.40pm. Nurse A advised her that there no signs of life and asked her to apply a defibrillator, which did not detect a shockable heart rhythm. The defibrillator continued to analyse the heart rhythm every three minutes and each time did not advise to shock.
65. Senior Officer B took Officer M to the staff room as he was very upset. A prison doctor and other healthcare staff arrived at the cell at around 1.50pm. The ambulance arrived at the prison at around 1.50pm and paramedics arrived at his cell at 2.00pm. The paramedics continued resuscitation and administered emergency treatment. The attempts to resuscitate the man were unsuccessful and, at 2.33pm, the prison doctor pronounced that he had died.

Contact with the man's family

66. Senior Officer O acted as the prison's family liaison officer. With a residential manager and the offender supervisor, she went to the man's father's home that afternoon and informed him of his death. Senior Officer O maintained contact with the man's family and offered support. Members of the man's family visited Moorland and told the Ombudsman's family liaison officer that the prison had managed their visit well. In line with national policy, the prison

offered financial assistance towards the cost of the man's funeral, which was held on 6 March 2014.

Support for staff and prisoners

67. A debrief was held later that day for the staff involved in the emergency response who were offered the support of the prison's care team.
68. Notices were issued to staff and prisoners informing them of the man's death. Officers and members of the chaplaincy were available to support prisoners. Those identified as at risk of suicide and self-harm monitoring were reviewed in case they had been affected by the man's death.

Post-mortem and toxicology reports

69. A post-mortem examination recorded the cause of the man's death as hanging. The toxicology report showed therapeutic levels of sertraline and olanzapine.

ISSUES

Medical care

70. The clinical reviewer concluded that the man received care equivalent to that which he could have expected to receive in the community. He made several recommendations about record keeping and medical care at Moorland, including the recording of medical and other information on electronic computer records which the Head of Healthcare will need to address.
71. The clinical reviewer found that the man did not have a recorded history of mental health problems when he first arrived in prison. However, he noted that he had been in a low mood after he was sentenced in 2010 and he was prescribed an antidepressant. From December 2013, the man's mental health appeared to deteriorate. He was referred to the mental health in-reach team on 17 January after staff and other prisoners raised concerns about his wellbeing. In the clinical reviewer's opinion, the man was managed well; appropriate clinicians, including a psychiatrist, were involved in his care and he took his medication. The clinical reviewer said that there was evidence of good multidisciplinary work within the mental health team.

Managing the risk of suicide or self-harm

72. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 states that "all staff that have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action". A list of potential triggers includes previous deliberate self-harm and mental illness.
73. The man was managed under ACCT procedures at Shrewsbury before he transferred to Moorland in December 2011. There were no further concerns about his wellbeing until he reported being bullied in December 2013. He was referred to the mental health in-reach team on 17 January 2014, but harmed himself on 19 January before he was seen. An ACCT was opened that day.
74. In the report of an inspection of Moorland, in 2012, inspectors found that there was a lack of multi-disciplinary representation at ACCT reviews, as happened in the man's case. PSI 64/2011 contains a mandatory action that a member of the healthcare team attends the first ACCT case review, but this did not happen. A member of the healthcare team attended only five of the eleven reviews. Four reviews were held without healthcare staff, chaplaincy or the man's offender supervisor. We do not consider these reviews to have been sufficiently multi-disciplinary.
75. The initial level of observation was set as four an hour, but this was revised twice on 20 January as the man's level of risk of suicide and self-harm was assessed as being high. At the second case review, the panel agreed that

constant supervision was appropriate. Constant supervision remained in place for eleven days until 31 January. The frequency of observations was then reduced to hourly while the man was locked in his cell. (It is not clear what the level was when the man was not in his cell.) At that time, the man's level of risk was still assessed as high. The change in the level of observations at the review on 31 January from constant supervision to hourly observations seems marked when his assessed risk of suicide and self-harm remained the same. At the review on 7 February, the man's level of risk of suicide and self-harm was assessed as low and his level of observations was reduced to just one in the morning, afternoon and evening and three at night. This appears to have been too quick a transition from high risk and constant supervision just a week earlier.

76. PSI 64/2011 states that a prisoner who is subject to constant supervision for more than eight days should receive an enhanced case review, which should be chaired by a senior manager, and should include more specialists and a higher level of operational management than a normal ACCT review. PSI 64/2011 suggests that a psychologist, offender supervisor, members of the chaplaincy team and Independent Monitoring Board and the manager of the unit where the prisoner is located should attend.
77. In the man's case, what was described as an enhanced case review did not take place until eleven days after constant supervision began. It was held at short notice on 31 January after the safer custody manager became concerned that the man had been constantly supervised for too long. The review team consisted of the safer custody manager (who was the manager responsible for the induction unit) and officers from Houseblock 3. However, there was no one from the mental health team present or anyone from any other disciplines. We do not consider that this constituted an enhanced case review as set out in PSI 64/2011 and, while we do not criticise the decision to end constant supervision, we are concerned that the decision was not made by a multi-disciplinary team. There is a mandatory requirement for prisoners on constant supervision to be reviewed daily but other than seeing a psychiatrist, on 28 January, there was no GP review.
78. PSI 64/2001 contains a mandatory action that caremaps should be completed after the first case review. The man's ACCT caremap was started at his third ACCT case review. Although this was only two days after the ACCT was opened, this meant that appropriate support was not identified for the man when it should have been.
79. Overall, we are satisfied that the man was well supported at the prison but some aspects of the ACCT procedures could have been better. While it would have been difficult to predict the man's actions on 10 February, we are concerned that his level of observations reduced too quickly. We make the following recommendation:

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

- **Holding multi-disciplinary case reviews which include all relevant people involved in a prisoner's care;**
- **Considering all known risk factors when determining the level of risk of self-harm;**
- **Setting appropriate levels of observations to reflect identified risk;**
- **Holding enhanced case reviews when a prisoner has been on constant supervision for eight days;**
- **Ensuring that a doctor reviews a prisoner on constant supervision every day;**
- **Completing ACCT caremaps at the first case review.**

The emergency response

80. When Officer M discovered the man hanging in his cell, he called for Officer L to assist. Officer L telephoned for emergency assistance as he did not have a radio, and used a code blue. Senior Officer B repeated the code blue over the radio, and the control room asked whether an ambulance was required. Senior Officer B confirmed that one was. The control room logged the emergency code as being received at 1.36pm and an ambulance was called at 1.38pm. Paramedics arrived at the cell at around 2.00pm, 22 minutes after being called.
81. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, issued in February 2013, contains mandatory instructions for prisons to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. Moorland issued a notice to staff in April 2013 (NTS 126-2013) which made it clear that an ambulance should be called immediately when an emergency response code is used. While this led only to a slight delay before the ambulance was called, this delay should not have happened. The control room need to understand that they should call an ambulance immediately a code blue is received. The PSI makes it clear that an ambulance can be cancelled if it is later assessed that it is not required. We make the following recommendation:

The Governor should ensure that the control room call an ambulance immediately they receive an emergency medical code.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Holding multi-disciplinary case reviews which include all relevant people involved in a prisoner's care;
 - Considering all known risk factors when determining the level of risk of self-harm;
 - Setting appropriate levels of observations to reflect identified risk;
 - Holding enhanced case reviews when a prisoner has been on constant supervision for eight days;
 - Ensuring that a doctor reviews a prisoner on constant supervision every 24 hours;
 - Completing ACCT caremaps at the first case review.
2. The Governor should ensure that the control room call an ambulance immediately they receive an emergency medical code.

Action Plan HMP Moorland 10th February 2014

No	Recommendation	Accepted / Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <p>Holding multi-disciplinary case reviews which include all relevant people involved in a prisoner's care;</p> <ul style="list-style-type: none"> · Considering all known risk factors when determining the level of risk of self-harm; · Considering all known risk factors when determining the level of risk of self-harm; · Setting appropriate levels of observations to reflect identified risk; · Holding enhanced case reviews when a prisoner has been on constant supervision for eight days; · Ensuring that a doctor reviews a prisoner on constant supervision every 24 hours; · Completing ACCT care maps at the first case review. 	Accepted	<p>All operational managers Band 4 and above have been contacted and sent a hyperlinked copy of PSI 64/2011 with specific and highlighted guidance on management responsibilities during the ACCT process and reviews. An aide memoire has been sent to operational managers with a copy placed in the front of all blank ACCT documents as guidance and areas to be considered by managers when involved in reviews.</p> <p>Multi disciplinary contacts are now notified of planned or scheduled ACCT reviews by the Safer Custody BA with a request to attend or send written submissions which will be included into the review. Information and findings from previous reviews is shared with recipients for information.</p> <p>Local policy has been published and implemented with a recommendation that If a prisoner's behaviour is particularly challenging, or is subject to constant supervision for 72hrs or more, they will be managed with the additional input of an Enhanced Case Review.</p> <p>A Local protocol is currently in place which ensures Monday to Friday cover by Doctors. If a Doctor is not in the establishment on the weekend a suitably</p>	COMPLETED	

Action Plan HMP Moorland 10th February 2014

No	Recommendation	Accepted / Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<p>qualified healthcare professional will make an assessment for prisoners on constant supervision. If any concerns are raised, the on call Doctor will be contacted to come into the establishment.</p> <p>All operational managers Band 4 and above have received clear guidance on the requirement of completing the care map during the first review and updating it during reviews.</p> <p>ACCT documents will be quality checked to ensure compliance:</p> <ul style="list-style-type: none"> · Multi disciplinary attendance or input. · Identification and documentation of risk and triggers. · Identified risk levels against frequency of observations. · Completion of ACCT care map at first review. · Frequency of healthcare / doctors interaction. 		
2	The Governor should ensure that the control room call an ambulance immediately they receive an emergency medical code.	Accepted	NTS 159/2014, Discovery of an apparent death in custody which contains clear guidance to all staff on actions to take was issued 15/07/2014 and will be re issued twice a year.	COMPLETED	