



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in March 2013
while in the custody of HMP & YOI Stoke Heath**

Our Vision

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

This is the investigation report into the death of a man at HMP Stoke Heath, who was found hanging in his cell on 22 March 2013. He later died in hospital a few days later. He was 26 years old. I offer my condolences to his family and friends.

A review of the clinical care which the man received in prison was undertaken. The prison cooperated fully with the investigation.

When he was first sentenced in February 2012, the man was sent to HMP Birmingham. He had a history of drug abuse, mental health problems and suicide attempts and was monitored for a time. In May, he moved to Stoke Heath where he was initially under the care of the mental health in-reach team and a psychiatrist. Although he had no diagnosed mental illness, he was prescribed antipsychotic medication to help stabilise his mood. His medication was changed several times and then stopped in January 2013 with his agreement. He was discharged from the care of the in-reach team.

The man's mood deteriorated towards the end of February and staff began suicide and self-harm monitoring procedures. Thirteen case reviews were held in three weeks because of his unpredictable behaviour and increasing self-harm. He said he needed medication again. He was referred back to the mental health in-reach team who saw him on 19 March, but he did not see a psychiatrist again before his death and was not prescribed any medication. He was still being monitored as at risk of suicide when he was found hanging in his cell on 22 March, just a short time after a member of staff had checked on him. Prison staff and paramedics were able to revive him but, sadly, he died in hospital several days later.

The investigation found that the man's mental health problems were not addressed with sufficient urgency and not all the available information was fully shared or considered so that the mental health team had a full picture on which to base their assessments. The clinical reviewer considers that he should have been referred directly to a psychiatrist in early March so that his need for medication could have been reconsidered.

Individual staff made considerable efforts to support the man and conducted thirteen case reviews under suicide prevention procedures. However, this care was fragmented and insufficiently well-coordinated to manage his complex needs, disciplinary action to deal with some of his challenging behaviour did not take into account his identified suicide risk and his allegations of bullying were not formally investigated. While it might not have prevented him taking his own life, a more consistent and co-ordinated case management approach might have ensured his case was considered in the round and his escalating level of risk more effectively identified and responded to.

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

February 2014

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SUMMARY

1. On 6 February 2012, the man received a 45 month prison sentence and was taken to HMP Birmingham. He reported a history of mental illness and suicide attempts. He stayed briefly in the healthcare centre and was monitored by the mental health in-reach team when discharged. He was monitored as a risk of suicide and self-harm for the first three weeks of his sentence.
2. The man transferred to HMP & YOI Stoke Heath on 11 May. He was under the care of the in-reach team and saw a psychiatrist a number of times. His medications were changed and doses altered to try to improve his mood. He also spoke to the Imam regularly.
3. The man began to report having problems with his marriage at the end of 2012 and he stopped taking some of his medication. He was monitored under suicide and self-harm prevention procedures for two weeks over Christmas and New Year until his mood improved. In January 2013, the psychiatrist stopped antipsychotic and antidepressant medication with his agreement. He was discharged from the in-reach team's caseload to the primary care mental health team.
4. The man's mood deteriorated in February. He said he felt paranoid and was experiencing delusions. The psychiatrist did not consider he had a psychotic illness and recommended talking therapies instead of medication. Staff began self-harm monitoring on 27 February and held 13 case reviews over the next three weeks, sometimes scheduled and sometimes in response to deterioration in his mood and behaviour. He swallowed batteries, smashed two televisions, flooded his cell and made ligatures from torn bed sheets on three separate occasions. He said that he was being threatened by other prisoners for a range of different reasons. These claims might have been part of his paranoid behaviour but they do not appear to have been investigated.
5. The primary care mental health team referred the man back to the in-reach team. After an assessment, an appointment was made for him to see a psychiatrist on 8 April. He was not prescribed any more medication.
6. On 20 March, the man was punished for bad behaviour. His television and opportunities to mix with other prisoners during association periods were withdrawn. On 22 March, it was decided at his last case review that his risk of suicide and self-harm had increased but there was no commensurate increase in the frequency of required observations. That evening, he rang his cell bell, said that he had swallowed another battery and asked to see a nurse. The night patrol officer arranged for a nurse to see him later during the medication round and, in the meantime, checked him more frequently than he was required to do. When he checked him at about 10.13pm, just seven minutes after his previous check, he found that he had hanged himself. Prison staff began cardiopulmonary resuscitation and were joined by paramedics. They managed to establish a pulse, but he never regained consciousness and died in hospital several days later.
7. While it is possible that the man's claims that he was being bullied and threatened by other prisoners were part of his paranoid behaviour, these

allegations of bullying were never properly investigated or referred to the safer custody department. When his behaviour and mental health began to deteriorate from the end of February, we consider that referrals back to the mental health in-reach team and then a psychiatrist did not happen as urgently as they should have done. Suicide and self-harm prevention procedures were used frequently to respond to deteriorations in his mood, reflecting a commitment to try to protect him. However, these were not always well coordinated. There was a lack of consistent case management and we have some concerns that the level of observations set did not always reflect the identified risk. Disciplinary procedures used to deal with his poor behaviour did not fully take into account his risk of self-harm. Some aspects of his punishments and withdrawal of privileges appeared to increase this risk without appropriate consideration of alternative approaches at case reviews. We make 12 recommendations.

THE INVESTIGATION PROCESS

8. The investigator visited HMP & YOI Stoke Heath on Wednesday 27 March and met the Governor, the Deputy Governor, the Chair of the IMB, a representative from the prison officers' union and the prison's investigation liaison officer. He visited D wing, where the man died, and collected all of the relevant records.
9. NHS Staffordshire Commissioning Support Services appointed a clinical reviewer to review the man's clinical care in custody. The investigator interviewed staff at Stoke Heath on 8, 9 and 10 May. The clinical reviewer joined him for the interviews with healthcare staff. The investigator gave verbal feedback about the preliminary findings of the investigation to the Governor and followed this up in writing on 13 May. He interviewed a further member of staff by telephone on 22 May.
10. A copy of the report has been sent to the local Coroner.

The man's family

11. Our family liaison officer contacted the man's family. They wanted to know:
 - Why his antidepressant and antipsychotic medication was stopped and was this decision reviewed?
 - Was any action taken after he claimed that he was being bullied and what contact did he have with the violence reduction officer?
 - How was he kept safe and what did self-harm monitoring involve?
 - Did he receive visits other than from his family?
 - Did he ever refuse food?
 - What steps were taken after he started swallowing batteries?
 - Should he have had margarine in his cell?
 - How well did the night patrol officer on 22 March know him?
 - What does the CCTV footage of the emergency show?
12. The man's wife and relatives both received copies of the draft report through their respective solicitors. The solicitor representing the relatives wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP & YOI STOKE HEATH

13. Stoke Heath holds men aged 18 years and over. Young adults, aged between 18 and 21 years, are mixed with adult prisoners. The man was living on D wing when he died. All the cells on D wing are single cells.

Healthcare

14. Primary physical and mental healthcare are delivered by Shropshire Community Health NHS Trust. The mental health in-reach team for those with severe and enduring illnesses is provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Substance misuse treatment services are provided by Crime Reduction Initiatives (CRI).
15. The prison has 24 hour healthcare cover with two members of healthcare staff on duty at night. There is no inpatient unit. GP surgeries are held everyday except Sundays, backed up by an out of hours service. There is a primary care mental health team and a mental health in-reach team. The in-reach team is based outside the prison and visits to provide treatment. Psychiatrists hold two half-day clinics at the prison every week.

Her Majesty's Inspectorate of Prisons

16. The last inspection of Stoke Heath was in March 2012. Inspectors commented that allegations of bullying were well investigated, that the quality of ACCT entries was generally good and showed that staff were aware of and cared about the personal needs of prisoners. ACCT case reviews were regular and timely with care maps which adequately addressed identified problems. Inspectors were satisfied that recommendations arising from the last two deaths at the prison had been fully considered and implemented. Mental health provision was regarded as comprehensive. Primary and secondary services were judged to work well together to provide a cohesive service.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that prisoners are treated fairly and decently. The 2012 IMB report did not identify any major concerns.

Previous deaths at Stoke Heath

18. In the last five years we have investigated two self-inflicted deaths at Stoke Heath. Although both previous investigations touched on mental health provision and ACCT processes, neither raised any issues directly pertinent to the man's case.

Assessment, Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk

posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

KEY EVENTS

20. The man lived in Middlesbrough with his wife and children. He was under the care of the local community mental health team (CMHT) but attended sporadically and usually after taking overdoses. The CMHT had not diagnosed a psychotic illness but suspected that he had some type of personality disorder. He had misused drugs including cannabis, amphetamines and MDMA (commonly known as ecstasy).
21. On 6 February 2012, at Crown Court, the man received a 45 month custodial sentence for burglary and breach of a suspended sentence. He was taken to HMP Birmingham.
22. When he arrived at the prison, the man showed symptoms of paranoia. He was afraid of being raped and thought that others were talking about him and were out to get him. He heard voices telling him to kill himself. He also had a repeated visual hallucination of a man in a red suit. He thought that the television was talking to him. He reported a family history of mental illness and that he had been sexually abused as a child. He told staff that he had taken 15 overdoses in the previous year, had been admitted to hospital a few weeks previously, had tried to hang himself and had abused prescription medication.
23. The man said that he had tried to harm himself because he was anxious about his trial and being sent to prison. He said that he would rather hang himself than be in prison and spoke about tying a bed sheet around his neck and spreading shower gel on the floor to make it difficult for staff to help him. Staff began Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures. On 7 February, he was admitted to the prison's healthcare centre for a mental health assessment. He threatened to hang himself if he was moved back to the wing. He saw a psychiatrist and asked about admission to a psychiatric hospital.
24. Healthcare staff requested the man's records from his GP and community mental health team. He was initially prescribed zopiclone (a sedative), citalopram (an antidepressant) and risperidone (an antipsychotic drug). On 22 February, a psychiatrist stopped risperidone and started him on olanzapine, a different antipsychotic drug. The ACCT monitoring ended on 25 February when he was no longer regarded as a risk of suicide.
25. On 5 March, the man moved to a residential wing after a psychiatrist discharged him from the inpatient unit. He was referred to the mental health in-reach team. His case was discussed at a multidisciplinary meeting and he was allocated to a nurse, who reviewed him on 7 March. His care plan required that he see a nurse every month, a psychiatrist every three months and to take his medication.
26. The man was monitored again under ACCT suicide and self-harm prevention procedures from 8 to 20 March after he said that he wanted to kill himself and was hearing voices. He moved to a different wing on 13 March. He refused to attend the mental health in-reach clinic in early April for a mental health review, but saw his allocated nurse on 12 April. He was no longer having hallucinations and said that he had bought quetiapine (an antipsychotic drug)

from another prisoner, which had helped. The nurse advised him not to buy illicit medication. He saw him again on 19 April.

27. A consultant psychiatrist saw the man on 24 April. He had stopped taking olanzapine five days earlier. The psychiatrist thought that he had a convincing history of psychosis and prescribed quetiapine because he said that the recent illicitly-obtained dose had helped alleviate his symptoms.

HMP & YOI Stoke Heath

28. The man transferred from Birmingham to Stoke Heath on 11 May 2012. In reception, staff identified that he had been under the care of the mental health in-reach team at Birmingham. He said that he did not have any suicidal thoughts and his history of taking overdoses was recorded.
29. The lead prison GP saw the man the next day, continued his prescriptions for citalopram and quetiapine and referred him to both the primary and in-reach mental health teams. Because of his paranoia, he was given a single cell on E wing (the induction wing). He was not allowed to keep his medication in possession.
30. A mental health nurse saw the man on 15 May. He told her that he no longer heard voices or had hallucinations, but was still paranoid. She placed him on the waiting list to be seen by someone from the in-reach team. Another mental health nurse saw him on 30 May when he said that he was desperate to move to a prison closer to his family.
31. The mental health in-reach team accepted the man onto their caseload. His care co-ordinator saw him regularly throughout the rest of 2012. In July, he complained to her that he was being 'picked on' by wing officers. He told her that he had spoken to a member of the Independent Monitoring Board (IMB) about this but the IMB has no record of this. He did not raise the issue again with her. On 29 August, he moved to G wing.
32. On 25 September, an associate specialist in forensic psychiatry saw the man. The psychiatrist replaced his prescription for quetiapine with risperidone to try to alleviate his anxiety and paranoia (not because she considered that he was suffering from a psychotic illness). She continued the prescription for citalopram but decided not to prescribe zopiclone.
33. The man suffered some side effects from risperidone and was prescribed procyclidine (used to treat tremors and the side effects of antipsychotic drugs). A doctor then stopped risperidone and re-prescribed quetiapine. He showed no signs of an acute mental illness and the doctor proposed a slow reduction in his antipsychotic medication once his mental health stabilised. The psychiatrist reduced his dose of quetiapine on 16 October as it was making him drowsy and changed his antidepressant medication from citalopram to fluoxetine.
34. The man was due to transfer to HMP Northumberland on 7 November, but refused as he thought that this was still too far from his family. He wanted to transfer to HMP Kirkclevington Grange, which was full. He complained, stating that the distance from his family was causing him mental anguish. The reply

to his complaint noted that HMP Northumberland was 109 miles nearer his home than Stoke Heath.

35. A psychiatrist saw the man on 27 November. He said he felt anxious, tired and paranoid, and had bought pregablin illicitly from another prisoner which had helped his anxiety. She prescribed gabapentin but did not change his antipsychotic medication, although he had asked to switch from quetiapine to amisulpride. She did not complete a Security Information Report about the illicit trading of pregablin on his wing.
36. In the early hours of 23 December, the man told a nurse that his mood was low and he was hearing voices. Staff removed razor blades from his cell and began ACCT monitoring. He said he was having relationship problems, was missing his children and was in debt for tobacco. At his ACCT review that afternoon, he said that he was feeling better but asked for his antipsychotic medication to be changed to amisulpride.
37. The care co-ordinator and a nurse saw the man on 24 December. He said he was thinking about harming himself and that other prisoners had threatened him and called him a grass. He showed no signs of a psychotic illness and said that he was taking his quetiapine
38. On the morning of 27 December, the man refused to take his medication and to see the care co-ordinator. That evening, a nurse saw him. He said that he had spoken to his wife on the telephone and she wanted a divorce. He asked to change his antipsychotic medication to amisulpride. He was reported to be much brighter at his ACCT review on 29 December. He was discussed at a mental health in-reach team meeting on 31 December. The staff reviewed his recent clinical record entries and noted that he was still subject to ACCT monitoring.

2013

39. The man's ACCT document was closed at his fifth case review on 8 January when it was noted that his mood had noticeably improved since Christmas. The psychiatrist and care co-ordinator saw him the same day. He told them his wife had said she wanted a divorce at the end of November and that his mood had deteriorated at that time. He said that he had stopped taking fluoxetine and gabapentin two weeks earlier without adverse symptoms. He was still taking quetiapine but asked to stop all three medications because he was feeling better and felt ready to do so. The psychiatrist agreed.
40. The psychiatrist told the investigator that she would not normally take a patient from three medications to none so quickly but she was reassured that the man had already stopped taking two drugs with no apparent ill effects and had coped well in spite of relationship difficulties. She noticed that he had been prescribed a lot of medications in the past which had not helped, and felt that he had personality issues which were more suited to therapy. He asked for medication to help him sleep but she did not prescribe any. She did not schedule a further review and advised that he could move from the care of the in-reach team to the primary care mental health team. She suggested that relaxation techniques might help more than medication.

41. The Imam told the investigator that the man seemed less tired and appeared to be managing without his medication at this time. He had told the Imam that his parents had paid a religious leader in Pakistan to pray for him and sacrifice an animal to cure him of his mental health problems.
42. A doctor saw the man on 10 January. He was struggling to sleep after stopping all his medication, but did not want to take any long-term medication. The doctor gave him a short course of zopiclone to help him sleep.
43. On 17 January, the man told the care co-ordinator that he missed his children. She showed him a relaxation breathing technique and encouraged him to put together a box of items which held sentimental value. He seemed bright and showed no signs of mental illness. The next day he asked for more zopiclone but the doctor declined to issue a repeat prescription.
44. The care co-ordinator saw the man on 31 January. He spoke about his forthcoming release. She found no evidence of a mental illness and planned to refer him to the primary care mental health team after their next appointment, in accordance with the psychiatrist's decision earlier in the month.
45. The man attended a board to decide his suitability for release on temporary licence on 18 February. The care co-ordinator saw him later that day after an officer telephoned the in-reach team. He said that he was struggling and that things were going bad. He said that he felt paranoid and was experiencing delusional beliefs. He asked for amisulpride but she told him that this would need to be discussed at the next multidisciplinary meeting because he was now due to be referred back to the primary mental health team.
46. The psychiatrist and care co-ordinator saw the man the next day. He discussed his relationship problems and was upset that he could not see his children. He could not accept that his wife wanted a divorce and hoped to be released on home detention curfew in May. He asked for amisulpride but the psychiatrist said that she could not prescribe an antipsychotic medication to stabilise his emotions. She told him that he would benefit from a talking therapy rather than medications, although no sessions were actually organised.
47. The psychiatrist did not prescribe any medication and did not see any symptoms of psychosis. She suggested a referral to a counsellor with ongoing support from prison officers and the primary care mental health team. She told the investigator that she thought that the man was looking for drugs because he changed his reasons for wanting medication when she initially refused him. She did not think that his symptoms were sufficiently serious to need the support of the in-reach team.
48. The man was discussed at the mental health in-reach multi-disciplinary meeting on 20 February when it was agreed that he should be discharged back to the primary care team. He was allocated to a nurse, who told the investigator that he was shocked by his discharge from the in-reach team. On 26 February, he was told that his application for release on temporary licence had been unsuccessful.

27 February

49. On 27 February, the man asked to see the in-reach team but was referred to a primary healthcare nurse because he had been discharged from the in-reach case load. He did not attend this appointment. He later told an officer that he feared for his life and wanted to move to the segregation unit. He said that another prisoner he knew from HMP Birmingham had been released, started an affair with his wife and 'taken out a hit' on him. He named a prisoner who was going to kill him for the other man. He insisted that he was not being paranoid and asked to move off G wing as soon as possible.
50. The officer filled in a security information report (SIR). Staff assessing the reliability of the intelligence suspected that the man might be trying to engineer a move off the wing because of debt issues, although there was no firm evidence to support this. The wing manager was instructed to interview him and report any information back to the security department with a view to the prison's police liaison officer looking at the allegations
51. At about 10.00pm on 27 February, the man smashed his television and cut his forearms with the glass. He alerted staff by pressing his cell bell. A nurse cleaned and dressed his wounds, which included a deep four-inch cut to his left arm. Staff removed the television and all sharp objects from his cell and began ACCT suicide and self-harm monitoring.
52. The man explained that he was having problems on the wing and feared that he was going to be attacked by other prisoners. He also said that he was having problems with his wife. He declined the Samaritans phone (a cordless phone which prisoners are able to use in their cells to speak directly to the Samaritans) or a Listener (Listeners are prisoners trained by the Samaritans to spend time with other distressed prisoners.) The man again asked to move off G wing. Staff checked him four times an hour until his first ACCT case review the next day.

28 February

53. At 10.15am on 28 February, an officer completed an ACCT assessment with the man, who said that other prisoners from Birmingham were targeting him because they believed that he had provided information to prison staff. He claimed that property in his cell was going missing or being damaged and said that he felt unsafe on G wing and at Stoke Heath generally. He told the officer that he had harmed himself the previous day because he had been taunted by another prisoner who knew his wife. He described his actions as a 'cry for help'. He said that he had no plan to take his own life and that hurting himself was a way to release anger and frustration and he felt lost and helpless. He said that he had little contact with his wife and children and asked staff to contact his wife on his behalf. He also asked to speak to the in-reach team.
54. A Senior Officer (SO) and an officer completed the man's first ACCT review with him immediately afterwards. No representative from healthcare or elsewhere in the prison attended. He now asked them not to contact his wife but said he wanted a transfer to a prison nearer his wife and children. The SO agreed to make an application for a transfer on his behalf. The two officers assessed him as a low risk to himself. They amended the frequency

of observations, requiring staff to have five conversations with him each day, check him during the lunchtime and teatime lock-ups and complete five checks during the night.

55. The SO completed the man's ACCT care map. The first issue was his problem with another named prisoner. The action agreed was to move wings. The second issue was education. He required a change of labour. The third issue was a transfer to a northern prison and an application was submitted.
56. The SO arranged for the man to move to D wing, where he was allocated a personal officer. He said he felt better after the move and officers arranged for him to telephone his parents.
57. At 3.30pm, the man returned from his education class visibly upset and was allowed a telephone call to his mother. Afterwards, his mother telephoned the prison to warn that he was likely to harm himself. Wing staff spoke to him and he said that there was a price on his head because of an incident before he came to prison. He said that he felt unsafe in Stoke Heath. Staff restricted him to the wing.
58. During the evening, a D wing manager and a nurse spoke to the man, who was very upset and said that his wife was about to take their children abroad. He repeated his allegations about a former prisoner's involvement with his wife and said he was worried for his safety at Friday prayers. Officers gave him the Samaritans telephone and reminded him that he could get support from the primary mental health team. They referred him to the Imam. The manager involved the security department because of the information he had provided.

1 March

59. The next morning the man had a disciplinary hearing for smashing his television on 27 February. He was found guilty and his punishment was suspended but he was told that he would lose his canteen, television and association periods if he was found guilty of another offence before 1 June. He told staff that there was a price on his head in Stoke Heath but refused to name the prisoners who were threatening him. His mood was low and he asked to see the Imam.
60. An officer completed a security information report (SIR) that day. He mentioned the man's problems with prisoners and former prisoners at Stoke Heath. He gave him a statement form to provide more information, including the names of the prisoners who were threatening him. He wrote down some names but then scribbled them out, screwed the paper up, placed it down his trousers and refused to give it back. The officer listened to some of his telephone calls to his mother in which he threatened to take his own life. He gave him another statement form which he agreed to complete but it does not appear that he did. An officer completed the SIR, commenting that further information was needed and that staff would continue to review him as part of the ACCT process.
61. A SO chaired the man's second ACCT case review that afternoon. The Imam and a nurse attended with the man. The SO told him that the security

department was investigating his allegations of bullying. (There is no evidence that an investigation was completed.) He reminded him that he could get support from the Imam and nurse. He assessed his risk to himself as low and maintained the same frequency of observations, which included five checks during the night. The man asked to see someone from the mental health in-reach team but the nurse reminded him that he was now under the care of the primary care mental health team. He asked to see the doctor to discuss medication to stabilise his mood. (He saw a doctor three days later, but there is no record they discussed his medication.) The SO told the investigator that he seemed positive and in much the same mood as the night before.

2 March

62. At 7.10pm on 2 March, the man requested and was given the Samaritans telephone. Later that evening, he repeatedly pressed his cell bell and told staff that he had swallowed 250ml of washing up liquid. The night orderly officer (NOO) and a nurse checked him, but the nurse did not consider there was any medical problem. He said that he would do anything to be taken to hospital to talk to somebody as he did not trust prison staff and wanted to be seen by someone independent. The NOO removed some objects from his room that he might use to harm himself, including detergent. He wanted to telephone the police but the NOO told him that this was not possible. An officer waited outside his cell door to keep an eye on him.
63. Staff increased the frequency of the man's ACCT observations to hourly. Five minutes after she began her checks, the officer looked through the observation panel and saw him lying on the cell floor. He did not respond and his eyes were closed, but his chest was rising and falling. Three officers went into the cell and moved him onto the bed to allow a nurse to examine him. He then cooperated and she found no signs of illness.
64. The NOO was consulting the duty governor by telephone about the frequency of ACCT observations when the man pressed his cell bell again and said that he had swallowed three AA batteries. A nurse checked him and contacted the out of hours telephone service and the local accident and emergency department for advice. They said that their policy was to X-ray somebody six to eight hours after they had swallowed batteries to make sure they had passed through the stomach. They said that he did not require immediate admission to hospital unless he was in pain and that he could be taken to hospital for an X-ray the next morning.
65. The man continued to threaten that he would do whatever was necessary to be taken to hospital. He was moved to a constant supervision cell on the same wing with the agreement of the duty governor. Officers took turns to watch him for an hour.

3 March

66. During the night, the man told the officer that he missed his wife and children. They discussed the consequences for his family if he tried to harm himself and he accepted that they would be devastated. At about 7.00am on 3

March, he was reported to be upset and crying but also talking about his future and his children.

67. A manager chaired the man's third ACCT case review at 9.15am in response to the events of the night before. The man, a nurse and a custodial manager also attended. He apologised for his behaviour the previous night and said that he had had a breakdown. He said that he had not actually swallowed any batteries and he was not currently planning to harm himself. He asked for medication and the nurse reminded him that he was now a primary care patient because this was felt to be more appropriate for his level of need. They discussed a possible transfer to HMP Northumberland and arranged for him to telephone his wife. The manager reduced the frequency of observations to hourly and assessed his risk to himself as low. He immediately returned to his own cell. Later that day, he received a visit from his parents, sister and nephew.

4 March

68. On 4 March, staff asked a doctor to see the man as he had not eaten for 36 hours, as he believed that his food was being contaminated. He said that he feared for his life. He asked to go to hospital but the doctor refused. He did not ask her for medication and she did not prescribe any as she did not have any concerns about him. She recorded an ongoing diagnosis of personality disorder. She told the investigator that she could not be certain if his paranoia was genuine. She asked him to leave the consultation when he became argumentative. He then attended his education class. Prisoners in the class subsequently told the teacher that he had spoken about killing himself.
69. A SO chaired the man's fourth ACCT case review. An officer, the Imam, the man and a nurse all attended. He said he was feeling good because of his visit the previous day. He again asked to see the in-reach team. The SO assessed him as a low risk to himself and reduced the frequency of observations, with five checks during the day, five at night and once during daytime lock up periods (lunchtime and teatime). The SO added a fourth goal to the ACCT care map, specifying additional contact with a member of the education department. That afternoon, he told the Imam that he thought his food was being contaminated and that everyone was corrupt.

5 March

70. At lunchtime on 5 March, another prisoner, who lived opposite the man, told wing staff that he was worried the man was going to harm himself. Staff checked him. Later, at 5.00pm, the man asked an officer for a new bed sheet and the officer provided one. The officer could not find his original bed sheet.
71. That evening, the man told an officer that, during the afternoon, he had tied a bed sheet around his neck and attached the other end to the bars of his window in order to hang himself but had stopped because of the impact it would have on his family. He said that his mood was low at night and he thought that this was because other prisoners were tampering with his food. He asked to see the in-reach team and was given a telephone call to his wife. He denied any further plans to harm himself. The officer raised the frequency of observations to hourly. A nurse checked him and he showed her the red

marks around his neck where he had tried to hang himself. He asked her what would happen to him if he swallowed batteries.

72. At 8.00pm, the man pressed his cell bell and told an officer that he had swallowed two AAA batteries and a three volt battery. The night orderly officer and a nurse attended with a metal detector from the segregation unit, which gave a positive result when waved over his chest. He asked to be taken to hospital to have the batteries surgically removed but the nurse told him that he would be checked by the GP the next day and might then be taken to hospital for an X-ray.
73. The nurse, who had 22 years experience working in a hospital accident and emergency department, persuaded the man to swallow some water to demonstrate that his gullet was not blocked by a battery. She was satisfied that he was not choking, that there was no urgency and that he could wait to be checked the next morning. She talked to him about his family and encouraged him to get out of his cell and attend education. He was tearful. They talked about how his children might visit him. She increased observations to every half an hour and arranged for him to be checked with the metal detector again in the morning. As she left the prison, she also asked a colleague to ask the Imam to see him the next day.

6 March

74. At 8.40am the next morning, the man complained of really bad chest pains after swallowing the batteries. At 10.15am, a SO chaired the fifth ACCT case review. The man and the Imam attended. There was no healthcare representation but the SO had spoken to a nurse by telephone before the meeting. The man behaved bizarrely. He said that he had swallowed batteries as a cry for help and asked for an emergency telephone call to his family. Staff decided that the best course of action would be for him to write them a letter instead. There is no explanation for this decision in the record of the ACCT case review.
75. The SO told the investigator that the man engaged well and became more positive as the review progressed. He assessed his risk to himself as low and reduced the frequency of observations to every two hours because he seemed rational and stable. He added a fifth issue to the ACCT care map; mental health problems. The action recorded was the appointment of a nurse and a planned referral to the in-reach team.
76. In the late morning, a prisoner informed D-wing staff that the man wanted to kill himself. At 12.15pm, he complained to wing staff that he was having more chest pains. In the early afternoon, a nurse saw him and sought advice from the hospital. They advised that he be brought in for an X-ray.
77. At 4.15pm, the man was taken to hospital by three officers rather than the usual two, because managers suspected that he was trying to engineer the trip. The police were also informed. He accused the escort officers of being corrupt and claimed that prison staff were poisoning his food. He refused to be seen by a doctor of Asian origin in case they had been paid to kill him. He asked passers-by what would happen if he swallowed a battery. The hospital

confirmed that he had swallowed three batteries, but he was told that these should pass without a problem.

78. When the man returned to Stoke Heath at about 8.00pm, one of the escort officers noted in the ACCT document that he might try to harm himself in order to return to hospital.
79. A SO chaired the man's sixth ACCT review at 8.15pm in the healthcare centre. A nurse and an officer attended. He explained that he had swallowed the batteries because he was unhappy on D wing, and wanted to move to E wing. He said that his children were his main concern and that he wanted to speak to his wife face to face about the future of their relationship. He said that his mood was unstable, had deteriorated and that he needed medication. He complained about having been discharged by the in-reach team. The nurse agreed to refer him to the in-reach team and a sixth goal was added to the care map that he was to speak to the in-reach team. (Although a referral had already been agreed at the ACCT review earlier in the day.) The SO increased the frequency of observations, requiring staff to check him at least twice every hour. They assessed his risk to himself as raised. He remained on D wing.

7 March

80. An officer chaired the man's seventh ACCT case review the next morning. A nurse, the man and an officer also attended. The previous level of risk and frequency of observations were both maintained.
81. The nurse referred the man to the in-reach team on 7 March because of his escalating level of self-harm. In the referral, she mentioned batteries and detergent but not that he had made a ligature from a bed sheet and had considered hanging himself. There were a number of options to indicate the urgency of the referral on the form, but none were ticked.

8 March

82. The following night, the man pressed his cell bell and asked the night patrol officer if he could unlock him and another prisoner so they could fight. On 8 March, a SO issued him with two warnings under the incentives and earned privileges (IEP) scheme for not cooperating with wing staff and reduced him from the enhanced level to the standard IEP regime. There was no reference to this in his ACCT documents.

10 March

83. At 9.00am on 10 March, the man told an officer that it would be good to die but he did not have any plans to take his own life that day. Later, he told an officer that a device had been placed in his chest so people could monitor his thoughts. The officer gave him a copy of his sentence expiry information because he was confused about the length of his sentence.

11 March

84. A custodial manager chaired the man's eighth ACCT case review on 11 March. An officer and another custodial manager attended but there was no healthcare representation. The man claimed that, since swallowing batteries, he had an object in his chest which was transmitting information to other people, who were then laughing at him. He was unsure if his wife had left him. Staff planned to ask the Imam to contact the man's wife. He said he was certain that his food was being contaminated by staff and prisoners. The review agreed to maintain the same frequency of checks (two per hour) and the same level of risk (raised). They planned for a mental health nurse and him to attend the next ACCT review.
85. The man's in-reach referral was discussed at the in-reach team's meeting the same day. He was accepted back onto their caseload and allocated to a mental health nurse for an assessment on 19 March.

12 March

86. At about 1.00am on 12 March, the night patrol officer performed a regular ACCT check on the man. He shone his torch into the cell and noticed a length of green bed sheet hanging from his window. The man was sitting up in bed. He explained that he used this to pull the window to, but the officer was not happy with this explanation. He called the three assist night orderly officers and all sheets were removed from his cell as a precaution.
87. A custodial manager chaired the man's ninth ACCT case review on 12 March. A SO, a nurse and the man also attended. He was emotional. He believed that people were talking about him and he asked to be sectioned. He thought that prison staff were part of a conspiracy. He repeated his claim about equipment in his chest and claimed that he was being sexually assaulted during the night. He would not say if the perpetrator was a member of staff or a prisoner.
88. The man said that his wife was provoking him on the telephone. He was distraught at the idea of not being able to see his children when he was released. The nurse explained that someone from the mental health in-reach team would see him on 19 March. He said that he had no current plans to harm himself but would not rule this out in the future. He spoke at length to the Imam about his faith. The review agreed to maintain the same frequency of observations and level of risk. The custodial manager told the investigator that the ACCT review lasted for about two hours. The incident during the night involving the bed sheet was not discussed.
89. Late at night on 12 March, the man said to an officer, 'Tell them bastards if they are brave come up'. The prisoner told the investigator that the man's aggression was directed at staff rather than another prisoner.

13 March

90. On 13 March, the man was issued with another IEP warning for refusing work. During the association period at about 7.00pm, he blocked his sink, flooded his cell and smashed his television. He talked about his wife and children and

asked to move to the segregation unit. A SO refused and thought it was better for him to stay on D wing. He threatened to flood his cell again. A manager gave permission for any items which he could use to harm himself to be removed from the cell. He was left with his bed and duvet. Staff continued to check him every half hour.

14 March

91. During an ACCT check in the early hours of 14 March, an officer noticed the man taking down a length of bed sheet from his overhead light fitting. He told him that he had been thinking 'about doing it' but had changed his mind. He said, 'I'm daft enough to hang myself' and 'one thing's for sure, I'm not getting out of this prison alive'. The three assist night orderly officers came and removed the torn sheet from his cell. A nurse checked him. In the morning, he flooded his cell again.
92. A nurse reviewed the man's mental health that afternoon. He said that he was still feeling suicidal, was likely to keep making ligatures and that only medication would help. He asked how to get a cell in the healthcare centre. She was concerned that he was escalating his behaviour to engineer a move to the segregation unit or the healthcare centre. She passed on her concerns for discussion at the next in-reach meeting. That evening, he threatened to smash up his cell to obtain a move to the segregation unit.
93. The man pressed his cell bell during the association period when he was locked up and threatened to assault somebody if he was not moved off the wing. At roll check, he would not move or communicate with staff. The orderly officer and emergency healthcare responder attended. He said that he would not cooperate during the night when staff completed their ACCT checks.

15 March

94. On the morning of 15 March, the man went to the segregation unit for an adjudication for smashing his television and flooding his cell on 13 March. A nurse assessed that he was fit for the hearing. He said that was trying to get a move to the segregation unit. A manager adjourned the adjudication hearing pending a report from healthcare. He stayed in the segregation unit because he said that he felt safer there.
95. A SO chaired the man's tenth ACCT case review in the segregation unit. Another SO and a nurse also attended. The nurse wrote up the record of the case review. He repeated several of his previous allegations. He said that he had had problems on every wing and had been labelled a grass by other prisoners. He said that he did not want to remain on D wing and asked for a transfer to another prison. He asked to be sectioned and assessed by an independent psychiatrist. The nurse agreed to ask the in-reach team if they could review him sooner than the planned appointment on 19 March. He said he did not have suicidal thoughts at the time but said that his mood fluctuated. Staff maintained the level of risk and kept the frequency of observations at twice each hour. He had initially felt safe in the segregation unit but now felt he was being monitored there as well. He decided to leave the segregation unit and return to D wing.

16 March

96. At 7.20pm on the evening of 16 March, the man pressed his cell bell and told an officer that he had swallowed a battery. He then refused to talk again, tampered with his light fitting, damaged property and flooded his cell. A nurse visited his cell and asked to be informed if he subsequently developed pain or breathing difficulties. She told the investigator that there was no particular urgency and he could be checked in the morning. He did not voice any suicidal thoughts. A manager attended and removed all furniture from the cell but not bedding. Staff understood that he had only had two batteries in his cell and two batteries were found after the incident, so they thought that he had not actually swallowed any.

17 March

97. A manager chaired the man's eleventh ACCT review on 17 March, after the events of the evening before. A SO, an officer and a nurse also attended. A disciplinary charge had been laid against him for flooding his cell. He refused to communicate during the review other than to say that he had smashed his cell up because he was bored. Staff maintained the same frequency of observations and level of risk. He had a visit later that day which a nurse observed. He seemed calm and relaxed and interacted well with his two female visitors. (Visits records show that only family members visited him.)

18 March

98. On the morning of 18 March, the man was due to attend a hearing in the segregation unit for damaging prison property by scooping water onto the floor of his cell on 16 March. However, a nurse advised that he was not fit for adjudication which should be postponed until he had seen someone from the mental health in-reach team. Later that morning an officer had a lengthy chat with him and wrote in his ACCT entry that he had got himself into a mess and did not yet consider himself to be at the bottom. The officer thought that this was worrying. He said he had no contact with his wife and children. Later in the day, he went to his education class.
99. The man was discussed at the monthly Safer Prisons Meeting. Staff noted that he was scared to leave the wing as he said that there was a price on his head. No additional action was recorded beyond ongoing ACCT monitoring.
100. At the request of nurses, a doctor provided advice in the clinical record on the same day, to say that, if the man claimed to have swallowed a battery, he should be taken to hospital for an X-ray 12 hours later.

19 March

101. In the early hours of 19 March, the man annoyed the other prisoners on his spur by repeatedly pressing his cell bell and thumping the walls of his cell. Later that morning, he was assessed by two nurses from the mental health in-reach team. One nurse was accompanying the allocated keyworker, who was new to the prison. The man said that he felt paranoid and claimed that his food was being tampered with. He said that he would harm himself if he was

not seen by a psychiatrist and admitted to hospital immediately. He said that he had stopped taking all of his medication in December, had felt better in January but had deteriorated in February. He asked for medication.

102. Although the man said some odd things, he was rational and the nurses found no sign of a mental illness. They were satisfied that he did not need urgent medication or immediate referral to a GP. They agreed to discuss him at their next team meeting and booked the next available appointment with a psychiatrist for 8 April. The nurses planned to review him in early April. Later that day, he refused to attend his education class or come out of his cell to associate with other prisoners. He was given a replacement television.

20 March

103. At 8.15am on 20 March, the man went to the segregation unit for two adjudications. He was charged with damaging prison property; smashing his television and flooding his cell on 13 March and flooding his cell on 16 March. Neither of these incidents were explicit acts of self-harm. On the basis of his assessment by the in-reach team the previous day, a nurse advised the adjudicator by email that he was fit for the hearing. The adjudicator recalled that he was calm, rational and reasonable during the adjudication and was not upset.
104. Because the in-reach team had advised the adjudicator that the man was fit to be adjudicated, she considered that this was a case of bad behaviour rather than a mental health issue. She believed that he was fit to face the consequences of his actions. She had no other information about his mental health. She was aware of him making ligatures and swallowing batteries during the previous three weeks as this had been mentioned at daily morning meetings for managers. She did not consult his ACCT document. He told her that he was not fit for the hearing. He said that he had flooded his cell so that he would be assessed and moved to a psychiatric hospital. He felt that staff were not listening to him and his behaviour was because he was not well.
105. The adjudicator adjudicated on both incidents and imposed consecutive punishments each lasting 14 days, meaning a total of 28 days for the man without his television and association periods. He also lost 75 percent of his earnings for this 28 day period, leaving him 25 percent for telephone calls and stamps. His ability to purchase goods from the canteen was also withdrawn from that date. He was able to have a shower and a telephone call each day and could attend work, training or education, although at the time he had no allocated activity. The adjudicator told him that he could appeal the decision on medical grounds, but the withdrawal of his privileges took effect immediately.
106. The adjudicator decided the level of punishment based on local guidelines and took into account the cost of the damage to property. She told the investigator that she was more lenient than normal with the man and did not escalate the level of punishment for the second adjudication. She could have imposed 21 days in line with the local punishment guidance, but instead imposed an identical consecutive punishment of 14 days.

107. The adjudicator did not write in the ACCT document. She told the investigator that she would not normally do this while adjudicating and that she expected the segregation unit staff escorting the man to make an entry while he was held on the unit. There is no evidence that she took into account the effect of the punishment on someone already regarded as at risk of suicide and self-harm. His visit to the unit and his punishment were recorded in the ACCT ongoing record by officers.
108. A manager chaired the man's twelfth ACCT review later that morning. A SO was the only other member of staff present. He engaged well this time and said he had a forthcoming visit from relatives that weekend. He said that he was not currently planning to harm himself. He agreed to attend education classes regularly. He was reported to seem positive and optimistic. The manager reduced the frequency of observations to hourly and reduced the assessed risk of him harming himself to low.

21 March

109. The Imam collected the man from the wing on the morning of 21 March and took him to the chapel quiet room. They spoke for over an hour. He was upset that his marriage was over and was afraid that he would lose access to his children. The Imam advised him not to telephone his wife too often because he risked alienating her further. He did not mention having any suicidal thoughts.
110. Later, the man saw his care co-ordinator on the wing when she was seeing another prisoner. He asked to speak to her but she declined to see him because he was no longer on her caseload. In the evening, he telephoned his parents to tell them not to visit because he did not want them to see him when he was unwell. An officer unlocked him between association periods to make the call as he was not allowed to associate with other prisoners as part of his adjudication punishment.

Day of the incident

111. On the morning of 22 March, the man declined to go to Friday prayers in the chapel. A worker from the substance misuse service spoke to him while he was locked in his cell. He declined any assistance but she planned to see him the following week.
112. A manager chaired the man's thirteenth ACCT review at 10.30am. He refused to attend, so the manager held the review in his cell with no other staff present. He noted that his conduct had been generally good in the previous few days but his behaviour had become erratic and he had declined to attend Muslim prayers that morning. At the review, he behaved erratically and refused to engage in full conversation but answered the manager's questions. The manager suggested that it might be helpful for his sister to attend a future ACCT review because they got on very well, but he said he did not want this. He told him about other sources of support but he declined these as well. The review lasted for about 25 minutes. The manager increased the level of risk that he might harm himself to raised. Although he identified that he was at greater risk, he did not amend the frequency of observations which remained at once an hour.

113. The man did not collect either his lunch or dinner. He was given his canteen (order from the prison shop) during the afternoon.
114. An officer started working a night shift on D wing at about 8.35pm and completed a roll check before the day staff left. During the roll check he spoke to the man who was lying in bed and said that he was okay at that time. He completed the roll check and made an entry in his ACCT document.
115. Three assist night orderly officers arrived for work at about 8.30pm and went immediately to E wing where a prisoner was having an epileptic fit. In his haste Officer A took a set of day keys rather than the usual night keys. The three officers remained on E wing for about half an hour.
116. The man pressed his cell bell at about 9.00pm and asked to see a nurse as he said that he had swallowed a battery. Officer B recalled that he was staring at him, grinning and giggling. He noted in the ACCT document that he had 'tried this last week'. (He had been briefed about events of the previous week.) Officer B told the investigator that it was very difficult to judge his mood. He suspected that his laughter was related to his mental health problems and described his mood as odd and peculiar.
117. Officer B did not immediately contact the night orderly officer (NOO) in charge of the prison, to discuss the man's request for a nurse, as he knew that the NOO was overseeing the transition to night state. This process is not usually completed until about 9.15pm.
118. Officer B went to see the man again briefly at about 9.37pm after he pressed his cell bell. He told the investigator that he raised his hand and smiled and asked what time the nurse would come to see him. He was smoking and the officer was reassured that he was not choking or vomiting after swallowing the battery.
119. After they had finished helping the prisoner on E wing, the three assist night orderly officers went to the Listeners' suite on F wing to return two Listeners to their cells. They had to take the prisoner who had been seeing the Listeners to D wing. While there, they spoke to Officer B, who said that the man might have swallowed a battery but had now settled down.
120. Officer B telephoned the NOO in the communications room at about 9.45pm. They agreed that the man was not in any immediate danger and that the nurse would check him during the medication round later that evening. They agreed that he would continue to complete additional random checks and would telephone the NOO if his condition deteriorated. The NOO did not discuss the fact that he had swallowed a battery with a nurse before making this decision.
121. The three assist night orderly officers later went to collect a nurse from the healthcare centre. They waited for her to prepare the medication and then began the medication round at about 10.00pm. They started on A wing, then moved to B wing, where the nurse spent several minutes with a prisoner.

122. Officer B checked the man at about 10.06pm. He told the investigator that he was lying on his bed and again raised his hand and smiled. This check is not recorded in the ACCT document but can be seen on CCTV coverage. The officer went to check him again at 10.13pm and found him hanging from the window in his cell. He had tied a piece of torn bed sheet around his neck and to the bars of the window. His feet were on the floor and his knees bent to the side. The officer walked to the end of the spur so he did not alarm the other prisoners and radioed a code blue emergency, requesting immediate assistance. He then went to the ground floor to switch on the landing light (which has to be done from the wing office) and waited for others to arrive. The spur gate is unlocked at night, so there was an unobstructed route to the cell.
123. Officer B had decided not to enter the cell alone. He had a cell key in a sealed pouch for use in emergency but told the investigator that he did not feel safe going into the cell alone. He said he could not see well enough to be certain that the man was definitely hanging. He was aware of his volatile behaviour in recent weeks and was concerned that this might be a trick. He was also aware that the assist night orderly officers were close by on B wing and so would arrive very quickly.
124. Three officers and a nurse were just about to leave B wing to continue the medication round when they heard the officer's radio message. The code blue emergency and location were confirmed in a follow-up call from the communications room. The officer waited for them at the wing office and shouted the cell location as they arrived. The officers and the nurse reached his cell at about 10.14pm.
125. Officer A reached the cell, opened the observation panel and shouted into the cell, which was still dark. Officer C was finding it difficult to use a small key to activate the cell light from the outside and Officer B passed Officer A's torch. He then saw that the man had hanged himself.
126. Officer A unlocked the cell door as he was still inadvertently carrying a set of day keys which include a cell key. (Normally the only cell keys available to staff at night are carried by the wing patrol staff in sealed pouches and by the night orderly officer.) There was an empty tub of margarine on the bed (which the man had bought from the prison shop as all prisoners are able to do). The floor was covered with margarine, making it very slippery. He was wearing a t-shirt and boxer shorts and had covered his arms and legs in margarine. Officer D supported the man's weight while Officer A cut the bed sheet from the window with a special cut down tool which all officers carry and then cut the other end from his neck. Officer C cleared the cell of furniture.
127. Officer D laid the man flat on the floor. The officers got no response from him. He was not breathing and had no pulse. The staff began cardiopulmonary resuscitation. Officer A was carrying a mouth shield and passed this to the nurse. The nurse gave rescue breaths and Officer B performed chest compressions. The nurse asked for an emergency ambulance and Officer A radioed this request to the communications room. The control room staff ordered an ambulance at about 10.18pm.

128. Officer D left the cell to collect a Healthcare Assistant (HCA) from the healthcare department because she did not have keys. The HCA collected a defibrillator and oxygen cylinder and waited at the gate to the healthcare department. They returned to the cell at 10.22pm. The nurse attached the defibrillator to the man, but it did not advise to administer a shock because there was no detectable heart rhythm. The NOO arrived and took over chest compressions from Officer B. The HCA left the cell again to collect more equipment at about 10.27pm and returned at 10.31pm. The first response paramedic arrived at the cell a few seconds later.
129. The first response paramedic and the nurse continued the resuscitation effort. They gave the man adrenaline and administered a shock when the defibrillator instructed to do so at 10.46pm and at 10.50pm, the nurse detected a strong irregular pulse. However, he did not regain consciousness and his pupils remained fixed and dilated.
130. Two more paramedics arrived at the cell at about 10.55pm and they took the man to hospital in an ambulance which left the prison at 11.16pm. An officer accompanied him in the ambulance and no restraints were used. Another officer followed in a car. Officer A relieved Officer B from his duties on D wing to help him deal with the shock. Prisoners subject to ACCT monitoring were reviewed that night.

The next day

131. Prison staff contacted the man's next of kin at 2.00am on the advice of the nursing staff at the hospital. His brother, sister and mother travelled to the hospital. At 7.50am, a manager held a hot debrief to support the staff involved in the emergency. She also spoke to the two escort staff who had returned from the hospital.
132. An X-ray at hospital showed that the man had swallowed three batteries. Plans to move him to a hospital in Birmingham were abandoned as he was too unwell. His family asked the hospital to wait for his father to return to the United Kingdom the next day before deciding whether to continue treatment. The prison Imam visited the family at the hospital over several days.
133. The man's life support machine was switched off with his family's consent. His relatives asked the Imam to say prayers before he died. He was pronounced dead at 9.05am. A post-mortem examination confirmed the cause of death as hanging. A partially-ingested battery was found. There was no evidence of any injury from an assault.
134. The Imam continued to provide support for the man's parents. An officer acted as the family liaison officer for the man's wife when he returned from leave on 25 March. The funeral was held on Thursday 28 March and the prison contributed towards the cost in line with national guidance.

ISSUES

Mental health care

135. The man was prescribed different antipsychotic and antidepressant medications during his time in prison. He was taking quetiapine, fluoxetine and gabapentin when, in January 2013, all three medications were stopped by a doctor, with his agreement. The doctor discussed her decision to stop his medications with the investigator and the clinical reviewer. She said that it took several consultations with him over a few months before she decided on the best course of action. She had reduced, amended and swapped his medication and ultimately decided that drugs were not helping him. The clinical reviewer completed a review of the man's clinical care. He comments:

'It was a reasonable decision not to prescribe any antipsychotic medication at this stage, despite the prescribing of various forms of this type of medication over the past year.

'... reasons can be made for and against prescribing at this stage I can find no fault in the decision that the doctor made, especially as she arranged a suitable follow-up appointment to enable her to review him and reassess her decision.'

136. The doctor reviewed the man as planned in mid-February, and decided not to re-prescribe any medication. He was then discharged from the mental health in-reach team (which is usually for those with serious and enduring diagnosed mental illnesses) to the primary mental health team. The clinical reviewer considers that this was a reasonable decision. He comments:

'The issue of whether medication should have been restarted between January and March 2013 is not an easy one to resolve. It would be easy, given the benefit of hindsight, to suggest that some form of psychiatric medication should have been restarted, particularly as a typical 'modern' antidepressant would have been a safe option, but there are arguments for and against this, and it is not clear whether this would have made a difference to the outcome. I can see no evidence of poor care given the decision that was made.'

137. After three weeks with the primary mental health team, the man was referred back to the in-reach team on 7 March because of his escalating level of self-harm. A nurse did not record the urgency of the referral on the referral form and did not include his recent account that he had tied a ligature around his neck and contemplated killing himself. The in-reach team manager told the investigator that, had the team been informed about him making a ligature, they could have considered either a more rapid referral to a psychiatrist, a telephone consultation with a psychiatrist to consider immediate medication (which a GP could have then prescribed) or discussed the possibility of constant supervision with a prison manager. She said that his use of ligatures should have resulted in an urgent referral to the in-reach team as this was a more serious manifestation of self-harm. We do not consider the referral to the in-reach team was given sufficient priority. We make the following recommendation:

The Service Manager for Secondary Mental Healthcare should ensure that mental health referrals highlight the most serious concerns about a patient and indicate the urgency of the referral.

138. Although there was no reference to the man tying ligatures in the referral of 7 March, his case was subsequently discussed at a mental health in-reach team review meeting on 11 March. The clinical reviewer points out that information about him tying a ligature around his neck on 5 March was available in the clinical record at that time, but the review meeting does not seem to have taken account of this. The entry in his clinical record about the meeting does not include any detail other than that he had been accepted by the in-reach team for assessment.
139. It appears that the man might actually have made three attempts to create a ligature before he hanged himself. As well as the incident on 5 March, during ACCT checks on the evenings of 12 and 14 March, an officer found him tying a torn bed-sheet first to the bars of his cell window and then to the light fitting in his cell. Each incident was recorded in the ACCT ongoing record but the in-reach team was never made aware of this pattern of behaviour. A primary care mental health nurse attended seven of the 13 ACCT case reviews held from 27 February onwards, but there is no record that the incidents involving ligatures were discussed at these reviews. As a result, his assessment by the in-reach team and a referral to a psychiatrist were not given a higher priority and the possible need to recommence his medication at that stage was not considered.
140. Two mental health in-reach nurses saw the man on 19 March, less than two weeks after he was referred to the team. The clinical reviewer comments:
- ‘My main concern was with circumstances involving the referral back to Secondary Care in March 2013 ... [t]hough it is hard to determine whether the outcome would have been different.
- ‘I would question the decision to arrange an assessment by In-Reach mental health nurses. Even though the referral letter lacked important information there was sufficient evidence in the letter, in the clinical notes and the MDT’s prior knowledge of his history to indicate there should have been a prompt review by a psychiatrist. The assessment by the mental health nurses gained little but added to the delay in seeing a psychiatrist.’
141. The in-reach workers booked an appointment for the man with a psychiatrist for 8 April at which they expected the need for medication to be reviewed. They did not refer him to a GP or psychiatrist for immediate medication because they did not think he was a high risk or acutely unwell. They had not been informed that he was repeatedly making ligatures, did not appear to take into account existing information in his clinical record and did not consult the ACCT ongoing record. We make the following recommendations:

The Governor and Service Manager for Secondary Mental Healthcare should ensure that all relevant information about mental health and risk of suicide and self-harm is discussed at ACCT reviews and summarised in the prisoner’s medical record.

The Service Manager for Secondary Mental Healthcare should ensure that mental health in-reach staff consult and take into account all the information in a patient's clinical record and other relevant sources when they discuss cases at weekly review meetings and refer the most urgent cases directly to a psychiatrist.

Swallowing batteries

142. The clinical reviewer considers that insufficient attention was given to the man's repeated claims to have swallowed batteries. This can be a form of self-harm. He told staff that he had swallowed batteries several times, although it is not clear if this was always true. The prison GP added some guidance for the nurses to his clinical record in response to their concerns when the incidents began to be more frequent. His batteries were not confiscated at any stage, despite his claims to have swallowed them as a means of self-harm. While this might have been difficult to enforce (because batteries from other prisoners' electrical items are easily obtainable) there is no evidence that it was ever considered at ACCT reviews. Other prisoners at Stoke Heath have also swallowed batteries as a form of self-harm. One of these prisoners was taken to hospital five times for this reason and had batteries removed for his own safety. We make the following recommendation:

The Governor and the Service Manager for Primary Healthcare should issue guidance about how staff should manage safely prisoners who claim to have swallowed batteries.

Managing the risk of self-harm

143. When the man experienced a crisis or his behaviour deteriorated, staff generally held an ACCT case review. There were 13 reviews in the three weeks from 27 February till his death. He also received ongoing support from the Imam, who saw him two or three times a week. The Imam also attended a number of the ACCT reviews. A case review was held no later than the following day on each occasion when he told staff that he had swallowed batteries. However, ACCT case reviews do not seem to have been prompted by staff finding torn bed sheets and potential ligatures.
144. The fact that the man began repeatedly to make ligatures was detailed in the ACCT ongoing record but was not discussed at case reviews. Making ligatures indicates a degree of preparation and an escalation in his potential self-harming behaviour which he had not previously displayed, and should have resulted in his level of assessed risk being raised. The presence of margarine on the cell floor and his body when he was found hanged, suggests that he was determined to succeed in taking his own life. We make the following recommendation:

The Governor should ensure that case managers discuss and record all potential and actual new incidents of self-harming behaviour at ACCT case reviews to help inform an appropriate assessment of risk.

145. In holding 13 case reviews in three weeks we are satisfied that Stoke Heath recognised that the man was at risk but the reviews were not well coordinated. Prison Service guidance is that ACCT case reviews should be multidisciplinary where possible and that the ACCT process will operate more effectively where there is continuity in attendance of staff from relevant departments and services. Seven of the 13 ACCT case reviews in February and March were attended by a mental health nurse. (Two other case reviews received some input from a mental health nurse.) However, six of the case reviews had no multidisciplinary attendance and the final review had only a case manager present with no other staff at all. Nine different case managers led the 13 ACCT reviews, which is poor practice and would not have assisted satisfactory communication or coordination and continuity of care. We make the following recommendation:

The Governor should ensure that there is continuity of case management in ACCT case reviews and that reviews include all appropriate people involved in a prisoner's care.

146. There were at least two occasions at ACCT reviews when we consider the man's risk was not appropriately assessed and the level of monitoring did not adequately reflect the level of risk assessed. At the ACCT case review on the morning of 6 March, a SO continued to assess his risk as low and he reduced the frequency of observations, despite him reporting that he had tied a ligature around his neck the previous day. It is apparent that this risk assessment did not appropriately take into account the evidence available; there is no record that ligature incident was even discussed at the ACCT review.
147. At the last ACCT review on 22 March, a manager raised the level of risk but did not increase the frequency of observations. He told the investigator that he raised the risk because of the man's refusal to come to the review. However, once the review was underway in his cell, the manager was not especially concerned about the risk of self-harm and he decided that hourly observations were still sufficient despite the raised risk. He said that he only raised the risk to reflect the change in behaviour, namely his withdrawal of cooperation.
148. Nonetheless, changes in behaviour can be an important indicator of risk. If the level of risk is raised, for whatever reason, there needs to be some indication how it is going to be managed. A change of risk assessment lacks meaning if there is no corresponding measure to manage the identified level of risk. In this case, maintaining hourly observations did not impact on the outcome for the man as an officer had conducted an additional check on him just ten minutes before he found him hanging. However, this was not a check he was required to complete or record. We make the following recommendation:

The Governor should ensure that ACCT risk assessments are based on all available evidence about the prisoner's mood and behaviour and that any assessed increased risk is reflected in the measures to manage it.

Disciplinary procedures and ACCT monitoring

149. The man was adjudicated against twice while subject to ACCT monitoring. At the adjudication on 1 March he was found guilty of smashing his television and received a suspended punishment. However, this incident was clearly related to self-harm on 27 February when he used the glass from the television to cut his arms. Prison Service Instruction 47/2011, which deals with prison discipline, states:

'It would not normally be appropriate to lay disciplinary charges where the prisoner's actions were related to self-harm or preparations for it... Such acts are more suitably dealt with through safer custody procedures than the disciplinary system.'

As his actions on 27 February were clearly related to self-harm resulting in a deep cut to his arm we do not consider that a disciplinary charge should have been laid. The adjudicator should have dismissed the charge when it came to the hearing.

150. Subsequently, the man was found guilty on 20 March of damaging prison property by flooding his cell and breaking his television. These incidents do not appear to have been related to self-harm but were part of an ongoing pattern of behaviour while he was subject to ACCT monitoring. His punishment meant that, apart from some attendance at daily food hygiene classes, he was only allowed out of his cell briefly each day for a telephone call and shower in the morning and to collect his meals. Prison Service guidance to adjudicators says that they should not combine punishments of forfeiture of privileges and exclusion activities so that they amount to cellular confinement by another name and that such punishments should not exceed the cellular confinement maximum of 21 days. Although he was not excluded from activity, he was restricted to cell for much of the day and the punishment lasted for 28 days. He was on the standard IEP regime at the time, but he had very little to occupy his time when he died.
151. The man's television was taken away and he had little contact with other prisoners but little to occupy his time in his cell. He did not have a cellmate. There is no evidence that staff offered him a radio, or provided him with a newspaper, hobby materials or books from the library. These small measures might have provided some distraction from his own thoughts.
152. The manager who carried out the adjudication on 20 March was aware that the man was being monitored under ACCT procedures, but went ahead on the basis that his mental health had been reviewed. There is no evidence in the adjudication records to show that she considered the possible impact of the punishment. Socialising with others can help reduce a prisoner's risk, rather than confining him to a cell. There was no evidence that safer custody staff were informed of the punishment to help manage the impact, contrary to the advice contained in Prison Service Instruction 47/2011, which states:

'If the outcome of the hearing (e.g., a severe punishment) is thought to raise safer custody concerns, the appropriate staff must be informed to aid management of the impact on a prisoner's risk of self-harm.'

We consider that she should have taken into account the impact of the punishment on someone who was regarded as a risk of suicide and self-harm and ensured that this was noted on his ACCT. We make the following recommendation:

The Governor should ensure that managers conducting disciplinary hearings for prisoners assessed as a risk of suicide and self-harm fully consider and record the impact of any punishment and actions taken to manage the risk and ensure the ACCT document is updated.

Managing prisoners at risk with complex needs

153. Although individual staff were heavily involved in the man's case, communication often failed and action was not always well coordinated. He might have benefitted from the enhanced ACCT case management process, as detailed in Prison Service Instruction 64/2011. This process brings with it a higher level of coordination between the different teams involved in the prisoner's care. It necessitates daily case reviews by a prison manager.
154. The man was not an automatic candidate for this intense level of supervision, but we consider his complex needs would have benefited from this more coordinated approach with some senior management involvement. Although his self-harming behaviour was not prolific and sustained he demonstrated destructive behaviour several times and repeatedly made nooses and swallowed batteries. The volume of case reviews in just three weeks suggests that additional case management might have been a helpful approach in the attempts to reduce his risk of harm to himself.
155. An enhanced case management process would have led to more effective sharing of information about all of the man's self-harming behaviour and risks, a more urgent in-reach referral, a more coordinated approach to the swallowing of batteries and better consideration of the impact of disciplinary procedures. While all of this might not have prevented his decision to take his own life, it might have provided a crucial level of support,

The Governor should ensure that staff are aware of and understand the enhanced ACCT case management approach and that is used appropriately for suicidal prisoners with complex needs.

Bullying

156. Any form of negative behaviour, including bullying, can be reported by staff on a Tackling Antisocial Behaviour (TAB) referral form. Four TAB forms were submitted to the safer custody department about the man while he was at Stoke Heath, but none related to bullying during his final period of ACCT monitoring. During late February and early March, as his mood deteriorated, he had told staff that he was being targeted by other prisoners acting on behalf of a man who was having an affair with his wife. It is not clear how much truth there was in this or whether this reflected his paranoia at the time. He alleged that another named prisoner would be the one to harm him inside prison, but it does not appear that there was any substantive evidence to support this.

157. The man made five separate allegations to different wing staff that he was being targeted by other prisoners on 27 or 28 February or 1 March. None of these incidents prompted a TAB referral to the safer custody department but an officer submitted a security information report to the security department. Based on the information in the SIR, the security team instructed the wing manager to interview him, obtain information and report back to them, with a view to involving the prison's police liaison officer. Although the managers on D and G wings both spoke to him, there is no evidence that they reported back to the security department or of any further investigation.
158. The wing manager moved the man off G wing onto D wing as an interim measure to keep him away from the prisoner he had named. There was no solid evidence to justify moving the other man and it was hoped that relocating him would help put his mind at rest.
159. Because no TAB form was completed about this matter, there was no monitoring or investigation completed to determine if he was the victim of anti-social behaviour. After this, he seems to have become less concerned about threats from other prisoners. He told the Imam that the bullying was indirect, such as people giving him looks. He spent a lot of time with the Imam, but he never disclosed the names of any alleged bullies to him or other staff.
160. It is conceivable that some of what the man said was the result of his paranoia. Nonetheless, appropriate investigations were not carried out to determine this and to decide whether or not the TAB procedures should have been used to support him. We make the following recommendation:

The Governor should ensure that all allegations of bullying are fully investigated and potential victims supported.

Request for a nurse on 22 March

161. The man asked for a nurse at 9.00pm on 22 March, saying he had swallowed batteries. Officer B did not notify the NOO of this until 9.45pm because he knew that he would be busy locking up the prison. The NOO did not consult the nurse but decided that she would check him when she reached D wing during the medication round. Officer B increased the frequency of observations because his behaviour worried him. He was being checked at frequent random intervals when he was found hanging, but with hindsight it is unfortunate that a nurse was not called at the time.
162. In these circumstances, when the man, who was on an open ACCT said he had swallowed batteries, an act of self-harm, we would have expected the staff involved to have consulted a nurse first before deciding that he should wait to be seen. We accept that some previous incidents had not required any immediate action but we consider it would have been prudent for the nurse to check him, even if a visit to hospital the next day was the most likely outcome. This emphasises the need for guidance to staff about managing prisoners who say they have swallowed batteries about which we have made a recommendation above.

Emergency response

163. When Officer B found the man hanging, he did not use his emergency key to enter the cell. He walked along the landing and radioed for help and his colleagues reached the cell exactly a minute after he discovered him hanging, so there was no significant delay. It is a matter for individual staff to make a risk assessment about entering a cell alone but we are surprised that he did not go straight into the cell when he knew that the man was regarded as a risk of suicide and had claimed to have self-harmed shortly before.
164. The clinical reviewer writes in his clinical review:

'I consider the medical care of the man's suicide attempt on 22 March 2013 to be without fault. It was conducted rapidly and appropriately and was successful in that a cardiopulmonary output was re-established and he was transferred to hospital without delay. Tragically he subsequently died from his injuries.'

165. Approximately five minutes passed between the officer discovering the man and the control room calling an ambulance. It is difficult to be absolutely precise because the clock on the CCTV footage is incorrect and witness statements and the at scene log are contradictory. Prison Service Instruction 03/2013 about medical emergency response codes states that control room staff should call an ambulance as soon as they receive a code blue or code red message. This instruction should have been actioned by managers by the end of February 2013. It is fortunate that the first response paramedic arrived quickly but an ambulance should be called immediately. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance as soon as they receive a code blue or code red message, in accordance with PSI 03/2013.

166. Prison staff did not contact the man's next of kin until more than three hours after he was found hanging in his cell. They only did this on the advice of the hospital nurses. Prison Rule 22 (1) requires staff to inform the next of kin at once if a prisoner becomes seriously ill and is taken to hospital. This is particularly important when a prisoner could be near death. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

RECOMMENDATIONS

1. The Service Manager for Secondary Mental Healthcare should ensure that mental health referrals highlight the most serious concerns about a patient and indicate the urgency of the referral.
2. The Governor and Service Manager for Secondary Mental Healthcare should ensure that all relevant information about mental health and risk of suicide and self-harm is discussed at ACCT reviews and summarised in the prisoner's medical record.
3. The Service Manager for Secondary Mental Healthcare should ensure that mental health in-reach staff consult and take into account all the information in a patient's clinical record and other relevant sources when they discuss cases at weekly review meetings and refer the most urgent cases directly to a psychiatrist.
4. The Governor and the Service Manager for Primary Healthcare should issue guidance about how staff should manage safely prisoners who claim to have swallowed batteries.
5. The Governor should ensure that case managers discuss and record all potential and actual new incidents of self-harming behaviour at ACCT case reviews to help inform an appropriate assessment of risk.
6. The Governor should ensure that there is continuity of case management in ACCT case reviews and that reviews include all appropriate people involved in a prisoner's care.
7. The Governor should ensure that ACCT risk assessments are based on all available evidence about the prisoner's mood and behaviour and that any assessed increased risk is reflected in the measures to manage it.
8. The Governor should ensure that managers conducting disciplinary hearings for prisoners assessed as a risk of suicide and self-harm fully consider and record the impact of any punishment and actions taken to manage the risk and ensure the ACCT document is updated.
9. The Governor should ensure that staff are aware of and understand the enhanced ACCT case management approach and that it is used appropriately for suicidal prisoners with complex needs.
10. The Governor should ensure that all allegations of bullying are fully investigated and potential victims supported.
11. The Governor should ensure that control room staff call an ambulance as soon as they receive a code blue or code red message, in accordance with PSI 03/2013.
12. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

ACTION PLAN: The Man – HMP Stoke Heath

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that mental health referrals highlight the most serious concerns about a patient and indicate the urgency of the referral.	Accepted	The Service manager will communicate with primary mental health staff to ensure that risk factors are highlighted within the referral documents. However secondary mental health services prioritise and indicate urgency of referrals.	December 2013	Health Service Manager
2	The Governor and Head of Healthcare should ensure that all relevant information about mental health and risk of suicide and self-harm is discussed at ACCT reviews and summarised in the prisoner's medical record.	Accepted	The Head of Safer Prisons will ensure that all relevant information about mental health and risk of suicide and self harm is discussed at the weekly MASH (Multi Agency Safer Health) meeting and recorded within the ACCT document. Head of Healthcare will ensure that all information discussed at the MASH meetings is summarised in a prisoner's medical record.	December 2013	Head of Safer Prisons & Equalities/ Health Service Manager
3	The Head of Healthcare should	Accepted	The Service Manager has met the Secondary Mental Health Services Manager and has	December 2013	Health Service

	ensure that mental health in-reach staff consult and take into account all the information in a patient's clinical record and other relevant sources when they discuss cases at weekly review meetings and refer the most urgent cases directly to a psychiatrist.		worked through a process in which all staff members will read clinical entries before multi-disciplinary meetings. All cases perceived by the multi-disciplinary meeting as 'urgent' will be referred to a psychiatrist via the direct appointment system.		Manager
4	The Governor and the Head of Healthcare should issue guidance about how staff should manage safely prisoners who claim to have swallowed batteries.	Accepted	The Head of Healthcare and the Governor will be liaising with local clinical leads to develop a policy on how best to manage prisoners safely who have claimed to have swallowed batteries. In the interim prisoners assessed as vulnerable in terms of swallowing batteries will be recorded in the CAREMAP and batteries will be removed from the prisoner's cell to ensure his safety. Furthermore, Healthcare will be contacted and asked to assess and make a decision about whether hospital treatment is required.	December 2013	Head of Safer Prisons & Equalities/ Health Service Manager
5	The Governor should ensure that case managers discuss and record all	Accepted	The Head of Safer Custody will ensure that all staff are reminded that all potential and actual new incidents of self-harming behaviour are recorded in the ACCT document and are discussed at the next review to help inform an	December 2013	Head of Safer Prisons & Equalities

	potential and actual new incidents of self-harming behaviour at ACCT case reviews to help inform an appropriate assessment of risk.		appropriate assessment of risk. This will also be included in refresher training.		
6	The Governor should ensure that there is continuity of case management in ACCT case reviews and that reviews include all appropriate people involved in a prisoner's care.	Accepted	The Head of Safer custody will communicate to case managers about the need to ensure continuity of case management in ACCT case reviews and that reviews are multi disciplinary and include all appropriate people involved in a prisoner's care. This will be monitored by Custodial Managers when they complete their weekly management checks and non compliance will be challenged and raised via the Safer Prisons monthly meeting. The commencement of Offender Supervisors chairing the ACCT reviews will also increase continuity of case managers chairing reviews. Case managers will also monitor that issues highlighted within the review are recorded within the care map and raised with the appropriate people.	December 2013	Head of Safer Prisons & Equalities
7	The Governor should ensure that ACCT risk assessments are based on all available evidence about the prisoner's mood and	Accepted	Case managers will be informed via briefings by senior managers, Notices to Staff and refresher training that increased risks are reflected in appropriate observations and meaningful conversations with the prisoner. This information will be shared with Healthcare, key workers and all relevant people involved in the prisoner's case	December 2013	Head of Safer Prisons & Equalities

	behaviour and that any assessed increased risk is reflected in the measures to manage it.		management.		
8	The Governor should ensure that managers conducting disciplinary hearings for prisoners assessed as a risk of suicide and self-harm fully consider and record the impact of any punishment and actions taken to manage the risk and ensure the ACCT document is updated.	Accepted	The Governor will ensure that all Adjudicating Governors will be informed to assess the risks of the impact of disciplinary punishments on prisoners who are on an open ACCT. This will be achieved via Senior Manager briefings, Safer Custody meetings and guidance in the segregation unit.	December 2013	Head of Safer Prisons & Equalities
9	The Governor should ensure that staff are aware of and understand the enhanced ACCT case management	Accepted	All band 5 and above operational staff will be reminded of when and how to initiate enhanced case reviews. Enhanced case reviews will be covered on ACCT case manager training in the future.	December 2013	Head of Safer Prisons & Equalities

	approach and that is used appropriately for suicidal prisoners with complex needs.				
10	The Governor should ensure that all allegations of bullying are fully investigated and potential victims supported.	Accepted	A reminder to staff will be made via a Notice to Staff that all allegations of bullying must generate a referral to the Safer Prisons department and that these will be raised at the MASH weekly meetings to ensure appropriate risk information is shared and prisoners can be supported.	December 2013	Head of Safer Prisons & Equalities
11	The Governor should ensure that control room staff call an ambulance as soon as they receive a code blue or code red message, in accordance with PSI 03/2013.	Accepted	The Governor will remind all staff via a Notice to Staff that an ambulance should be called immediately when a code red or a code blue is called as per instruction in PSI 03/2013	December 2013	Head of Operations
12	The Governor should ensure, in line with Prison Rule 22, that	Accepted	The Governor will ensure that the next of kin is informed without delay of seriously ill prisoners. This will be achieved by the Governor making Senior Managers aware and Notice to Staff.	December 2013	Head of Safer Prisons & Equalities

	the next of kin of seriously ill prisoners are informed as soon as possible.				
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