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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death a man at HMP Hewell in  
January 2012**

## ***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 report of an investigation into the death of a prisoner at HMP Hewell. He was 33 years old. Shortly before 2.00pm on 6 January 2012, the man was found hanging in his cell. He was pronounced dead shortly afterwards. The post-mortem recorded the cause of death as hanging. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer, on behalf of NHS Worcestershire, carried out a review of the man's medical care in custody. Staff at Hewell cooperated fully with the investigation.

When the man was initially remanded to prison in December 2009, he was made subject to suicide prevention measures as he had a history of self-harm and substance use and mental health problems. Monitoring continued until May 2010, when he was assessed as no longer at risk. He was released on licence in December but, eight months later, returned to Hewell charged with new offences. During this period of custody he was not regarded as a risk of suicide, but healthcare staff conducted regular mental health and medication reviews. I agree with the clinical reviewer's opinion that the man received clinical care equivalent to that he could have expected in the community.

In spite of the good overall care, the investigation found some weaknesses in the man's management. He began working as a Listener in November 2011. He appeared to enjoy this role and was well supported, but healthcare staff were not consulted before his appointment. He also started working as a reception orderly around this time but was suspended from the role on 3 January 2012 pending an investigation. The reasons for this decision were not properly documented or justified in the man's case record. The following day, the man appeared at court. He did not get bail as he had apparently hoped.

During the morning of 6 January, the man sounded upset on the telephone to his partner. He was concerned about the length of sentence he would receive and they also had a personal disagreement. His position as a reception orderly had not been resolved. The man was found hanging in his cell after lunch, having used a bed sheet jammed into a cell toilet door. Staff had some difficulty cutting him down, but responded calmly and competently in trying to resuscitate the man. Although the man had previously been regarded as a risk of self-harm, I am satisfied that it would have been difficult for prison staff to predict and prevent the man's actions that day.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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## SUMMARY

1. The man was remanded to HMP Hewell on 24 December 2009, having been charged with arson. On reception at the prison, he acknowledged previous and existing suicidal feelings and was immediately placed under suicide prevention measures. The man was diagnosed with a personality disorder and prescribed sleeping tablets, anti-depressant and anti-psychotic medication.
2. After he was sentenced in May 2010, the man was no longer subject to suicide prevention measures as he told staff he had received a shorter sentence than expected and felt more able to cope as a result. The man was not considered to be a risk of suicide or self-harm again during his time in prison. Although there were some concerns about the man's mental health, based on the information known to staff, we believe that this was a reasonable assessment.
3. In December 2010, the man was released on licence. In August 2011 he was charged with a further offence, recalled to prison, and returned to Hewell. He was regularly assessed by doctors, prescribed medication for his mental health issues and received an appropriate level of care. The man began working as a Listener (a prisoner trained by the Samaritans to assist other prisoners who need to talk in confidence) in November 2011, a job which he appeared to enjoy. He was suitably trained and supported for this role, although, unlike other departments in the prison, healthcare was not consulted before his appointment.
4. In November 2011, the man also began working as a reception orderly (a job for a trusted prisoner). He was suspended from this role on 3 January pending an investigation, apparently because some staff had concerns about his past, although the details were not recorded in the man's case notes. We make a recommendation about the need to keep a record of relevant personal information. The following day, the man appeared at court. Before leaving for court, he asked what was happening about his job as an orderly and was told that the investigation was ongoing. As the sentence for which he had been recalled had expired, the man appeared to have hoped he would be given bail by the court that day but he returned to Hewell still remanded for outstanding charges.
5. During the morning of 6 January, the man made three telephone calls to his partner. Among other things, they discussed the seriousness of the charges he was facing, the length of sentence he might receive and they also had a personal dispute. He seemed upset during these telephone conversations. The man also discussed these concerns with another prisoner. He again asked an officer what was happening with his orderly job. He was locked in his cell for lunch at 12.10pm
6. When an officer unlocked the man's cell, shortly before 2.00pm, she found him hanging with a bed sheet around his neck. Staff reacted in a calm and competent manner in their efforts to save the man. A senior officer (SO) went

beyond what could reasonably be expected in trying to resuscitate the man without a face shield to protect him. The man never regained consciousness and was pronounced dead by the prison doctor around 2.10pm. During the debrief, staff said they had some difficulty in cutting the man down and cells could be made safer by removing the top of toilet doors.

7. The clinical reviewer concludes that it is likely that the number of stresses the man was feeling, over which he had little control, were compounded by his personality disorder and emotional instability and that these factors contributed to the impulsive act to end his life. We do not believe staff at the prison could have reasonably predicted that the man would act in such a way or prevented him from doing so.

## THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified of the man's death on 6 January 2012. The investigator, issued notices inviting staff and prisoners to contact her with any relevant information. There was no response. The investigator visited HMP Hewell on 16 January and met the Deputy Governor and members of the Independent Monitoring Board (IMB) and the Prison Officers' Association. She visited the man's cell and collected relevant documents.
9. On 28 January, 28 February, 27 March and 12 April, the investigator interviewed a number of staff and prisoners at Hewell. The investigator gave verbal feedback on the progress of the investigation to a senior manager after the interviews were completed. NHS Worcestershire commissioned A clinical reviewer reviewed the care the man received at Hewell. The doctor completed this on 1 June 2012. A copy is attached as annex one of this report.
10. Her Majesty's Coroner for Worcestershire was notified about the investigation and provided a copy of the post-mortem and toxicology reports. The Coroner will receive a copy of this report. The investigator also liaised with Worcestershire police who confirmed that their investigation had found no suspicious circumstances.
11. One of the Ombudsman's family liaison officers, contacted the man's partner, his nominated next of kin, to explain the purpose of the investigation and invite her to ask any questions or concerns about the care the man received in prison. She did not raise any concerns at that time.
12. The family liaison officer also contacted the man's mother, who raised the following issues:
  - How had the man been able to hang himself from a low fixed point? (In fact, the man used the door to the toilet area, which was a full-sized door.)
  - Had the man's work as a Listener affected his mental state?
  - What had happened on the day of the man's death?
  - Whether he had been monitored under suicide prevention measures?
  - Why had the man's attitude changed since he had been positive about getting out of prison when she spoke to him?

## **HMP HEWELL**

13. HMP Hewell was created by an amalgamation of three former prisons (HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange) on the current site on 25 June 2008. Each of the three sites accommodated a different category of prisoner – Category B, Category C and Category D. However, the category C site was closed in September 2011. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape.)
14. Hewell has eight houseblocks and holds up to 1,261 prisoners. The prison primarily serves Worcestershire, the West Midlands and Warwickshire. Healthcare at the prison is provided by Worcestershire Health and Care NHS Trust who provide 24 hour care in the inpatient wing.

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

15. The prison was most recently inspected by HM Inspectorate of Prisons during an announced inspection between 2 and 13 November 2009. The Chief Inspector made the following comments:

“Relationships between staff and prisoners in the closed part of the prison were good, and exceptionally good on house block 7. Staff were, with a few exceptions, respectful and helpful ...

“Many aspects of the management of self-harm and suicide were good, although we had several concerns. We were not assured that prisoners in house blocks 1-6 had 24-hour access to Listeners. Samaritans telephones had been withdrawn on house blocks 1 to 7. On our night visit to house blocks 1-6, not all the patrols were carrying anti-ligature knives. ...The quality of self-harm monitoring documents was mixed.”

“Health services included a wide range of clinics delivered by in-house and visiting specialists. Primary care services were generally good, but access to all services varied between house blocks, and prisoners' perception of healthcare was poor ... There was mental health support from primary and secondary teams, but there were no daycare services for prisoners with low-level mental health needs.”

## **Independent Monitoring Board**

16. All prisons in England and Wales have an Independent Monitoring Board (IMB). IMB members are unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. In their most recent report, for the period December 2010 to November 2011, Hewell's IMB were positive about management achievements in the face of budget reductions. The IMB praised the more timely service to prisoners requiring mental health input. The Board was also satisfied that prison staff had an effective approach

towards the maintenance and management of low levels of violence, self-harm and bullying in the prison.

### **Previous deaths at HMP Hewell**

17. Eleven prisoners have died at Hewell in the two years before the man's death of whom three were apparently self-inflicted. None of these investigations raised issues pertinent to the death of the man.

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

18. The Assessment, Care in Custody and Teamwork (ACCT) system is the prison service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself.
19. 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. Levels of supervision (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and should be set according to the perceived risk of harm. As part of the process, a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings, including the prisoner at risk.

## KEY EVENTS

20. The man had a difficult childhood and began misusing substances including glue, cannabis and crack cocaine from an early age. He reported depressive episodes and self-harm, although there is no record of any significant involvement with a community mental health team or drug agency before he was remanded to Hewell in 2009. He had previously been in prison for two short periods, each of six weeks, before his most recent sentence.
21. Immediately before his imprisonment in 2009, the man's misuse of alcohol, cocaine and cannabis had increased. There were recorded episodes of self-harm by cutting, a hanging attempt and an overdose of heroin. He subsequently set fire to his flat, apparently to kill himself, and was assessed by the Crisis Intervention Team at University Coventry Hospital. They found that the man was not suffering from a mental disorder which warranted hospital admission and at the end of the assessment, on 24 December 2009, he was charged with arson with intent to endanger life.
22. The man was remanded into custody and immediately made subject to assessment, care in custody and teamwork (ACCT) measures. For the following five months, the man was given additional support through the ACCT process, as well as medical treatment. A prison psychiatrist diagnosed that the man had borderline personality disorder with depressive features and prescribed olanzapine (an anti-psychotic drug) and venlafaxine (an anti-depressant). The man continued to have regular psychiatric reviews and remained on his prescribed medication.
23. The man was convicted of arson at Warwick Crown Court on 29 March 2010 and, on 13 May 2010, was sentenced to two years imprisonment. The following day, his ACCT monitoring ended. The case review stated:

“Had a long talk with [the man] about his sentence and he is very happy about the 2 year sentence. With his remand time he should have less than 6 months to do. He has plans for his release and is planning his marriage to his girlfriend. [The man] has been asking for a long time for the ACCT to be closed as he finds it more of a hindrance for going to the gym etc.

“The ACCT was kept open as he originally faced a lengthy sentence and as the sentence is much shorter than expected I am happy to close this document, with [the man's] agreement as he is still happy and fully aware of all his avenues of support available. [The man's] only concern is he wishes to transfer to Onley. I have informed him to apply to OMU and request this.”
24. The post-closure ACCT review was held on 7 June, as scheduled which noted that the man was “a lot more settled and positive in mood”. This was the last time the man was monitored under ACCT procedures.

25. It was noted in the man's case record on 24 July that he had demonstrated a consistently good attitude on the wing and in his place of work. During the months before his release, the man expressed some anxieties about living in approved premises (formerly known as probation hostels) and his ongoing relationship problems. However, there was no record of any thoughts of self-harm or suicide.
26. On 24 December 2010, the man was released on licence to Nuneaton Approved Premises, where he was under the supervision of the local Probation Trust. He was also referred to the community mental health team (CMHT).
27. After nearly eight months in the community, on 22 August 2011, the man was charged with possession of class A drugs with intent to supply and returned to Hewell. He was also on police bail for possession of a firearm.
28. The clinical reviewer notes that the man,

“underwent a further robust and complete Reception Screen, again including physical and mental health assessment, and was questioned regarding deliberate self-harm and suicide. He was recorded as having received Olanzapine, Zopiclone and an antidepressant in the community. The Olanzapine was continued and Healthcare contacted his General Practitioner to summarise his mental health history. His previous history was noted, including previous self-harm. No concerns were recorded on the assessment on this return to prison, and he was recorded as being mentally stable. However, in view of the history of self-harm and a request by the man to be supported by the Mental Health Team whilst at HMP Hewell, he was referred using the TAG (Threshold Assessment Grid) assessment tool to the Mental Health Team. It was also recorded that he was advised of the support available to him and how he could access this support as and when required.”
29. On 25 August, the man appeared at Nuneaton Magistrates' Court via videolink. He was remanded to Hewell until 20 September. Warwickshire Probation Trust recommended that the man should be recalled since he had potentially breached condition 5(i) of his licence to “be well behaved, not commit any offence”. His offender manager (probation officer) regarded the new charges as a worrying potential escalation in the seriousness of the man's offending.
30. A fellow prisoner, had known the man for a number of years in the community. They had also been at Hewell together the previous year. When the man returned to prison, the man's friend said he had been worried about the charges he was facing and whether he would be charged with possession of a firearm. He said he thought the man's relationship with his partner seemed to have improved since his previous time in prison when it had been an ongoing concern for the man.

31. An officer had also known the man from his previous time at Hewell. She told the investigator that, when the man returned, he initially settled back to life in prison well, knew people on the wing and seemed quite happy.

32. The clinical reviewer writes:

“On 8/9/11 the man was assessed by a prison doctor and he requested to go back on to his antidepressant medication and a further referral to the Mental Health Team was made after completing the TAG mental health tool again. There were no concerns noted regarding self harm or suicidal intent, although the doctor doing the assessment commented that he did not feel that the man really wanted to answer the questions. On subsequent review on 12/9/11 he was prescribed Zopiclone due to poor sleeping but again he was recorded as having no self-harm thoughts or suicidal ideation and no psychotic symptoms. He continued to be discussed weekly in the Healthcare MDT (multi-disciplinary team) meetings.

“On 15/9/11 the man was assessed by a psychiatrist and he was recorded as ‘feeling on edge and having bad thoughts all the time.’ His Olanzapine was continued and he was prescribed Zopiclone.

“He continued to struggle with poor sleep and low mood and on 3/10/11 he was recorded as having been experiencing some thoughts of self harm but did state that he was not intending to harm himself. A note was made to consider psychological therapy and group work and to discuss in the MDT meeting the medication review and possible anti-depressants. There is no evidence in the man’s records to show whether staff considered opening an ACCT to provide support as well as medical treatment.

“On review by the psychiatrist on 6/10/11 the man was prescribed Mirtazapine (an antidepressant) and continued on Olanzapine and Zopiclone...

“On 19/10/12 the man consulted with one of the prison doctors stating that his antidepressants were not helping but he felt that the mental health team would be more appropriate and it was agreed that he would contact them regarding review of his medications as they had commenced the antidepressants.

“There were further notes from the MDT meetings on 13/10/11 and 20/11/11 evidencing discussion at these meetings and concluding ‘no major issues with cutting or his anti-depressants,’ ‘manage for crisis care only’ and advising ‘if appears to be ill transfer to the seg and be assessed there,’ but no specific concerns were raised or discussed and the action plan was that a member of the team would monitor ‘low key’.

“A record on 7/11/11 suggested a discussion about treatment at the MDT weekly review with a note that ‘meds have been ok and medication compliance’ with the note that a nurse would keep an eye on him and his

medication would be continued. There were no subsequent formal reviews, assessments or clinical entries but the man's medication was continued."

33. On 12 November, an officer made the following case note entry:

"He [The man] has changed of late, he appears in a different world to others, he is quiet and has started to go sick from work, when trying to talk to him he isn't interested, needs to be monitored."
34. The officer told the investigator that the man, "...spent a lot of time in bed and just generally seemed quite down". She explained that the above case note entry was to alert other officers to monitor the man's mood.
35. Six days later, on 18 November, an entry in the man's case notes recorded an improvement in mood and that he was attending and enjoying a Listeners' course. The man's training as a Listener finished on 22 November.
36. The man started work as a Listener on 27 November, and staff wrote in his case notes that he seemed to be enjoying the role. The officer said that he also became an orderly in reception around the same time, although the prison was unable to provide the investigator with the date the man started this job. This involved him cleaning reception, making up packs for new prisoners, serving meals at lunchtime and being involved in the daily running of reception. As a reception orderly, prisoners are unlocked for most of the day. One of the reception managers, told the investigator that the man was quiet and did not talk to him or the other orderlies much.
37. On 11 December, staff recorded in a case note:

"The man seems to be enjoying his role as a trained Listener. He comes across as a quiet prisoner who interacts well with others. Treats people with respect and is always polite."
38. On 3 January 2012, the reception manager suspended the man from his job as a reception orderly, apparently because some staff were unhappy that they had been involved in restraining the man when he had originally come to Hewell (in 2009) when they thought he might be in possession of illegal drugs. (Prisoners can be restrained in such situations so that the drugs can be recovered and to avoid the prisoner harming themselves trying to hide the drugs.) The officers believed that the man might have held a grudge against them and therefore would not be suitable for the trusted orderly position. The reception manager was to investigate the matter further. It does not appear that the man was told the reason.
39. The man attended the weekly Listeners' meeting on 3 January. A Samaritan volunteer with responsibility for training Listeners at Hewell, said he seemed as vocal as the other members and confident in his role. She said there was nothing to indicate he was depressed, closed off or overburdened. Another Samaritan volunteer, confirmed that the man had attended every weekly meeting since he had started as a Listener.

40. The next day, 4 January 2012, the man appeared at Warwick Crown Court. While he was in reception waiting to leave the prison, the man asked the reception manager what was happening about his job as an orderly. The reception manager told him that he was looking into the matter and would have an answer soon and definitely by the following day at the latest. He told the investigator that the man appeared fine, did not look particularly anxious and was happy with the reply. The reception manager ended his shift at lunchtime and did not have time to complete the investigation that day. The reception manager said he had begun looking into it the next day but could not find any details of the incident in 2009 on the man's case notes and the investigation remained ongoing.
41. At court, the man's case was listed for trial at a date to be arranged. The man's friend told the investigator that the man had thought that he might be bailed as he had completed his original sentence for arson. The man did not get bail but returned to Hewell on remand. No one assessed his mood in reception when he returned to check how he was feeling on return from court.

## **6 January**

42. On 6 January, the man made three calls to his partner on the prison phone system. The investigator listened to recordings of these calls.
43. The first call was at 8.50 am. The man and his partner discussed whether or not his co-defendant had been released on bail. The two men had not appeared in court at the same time so the man did not know. His partner had heard that he had been released and said that she would find out whether he actually had.
44. Later in the morning, the man spoke to the officer. He asked her if she could find out any information about why he had been suspended from his job as reception orderly. The officer told the investigator that the man seemed fine as he spoke to her. She told him that she would try and find out what was happening and she would speak to him when she unlocked him for lunch. The officer said that all those who were not working on the houseblock, which included the man were normally locked in their cells around 9.30am.
45. However, at 10.00am, the man was out of his cell and he telephoned his partner again. She confirmed that his co-defendant had been given bail. The man said that the other man had appeared in a different court on 5 January. He sounded very upset and he and his partner discussed what he should do next. They feared that the co-defendant being given bail was a bad sign for the man. His partner urged him to fight the charges, saying that if he was convicted and given a ten year sentence he probably would not come out. The man told her that he had called his solicitor, who said she would make another bail application on his behalf.
46. Earlier in the morning, the man had gone to the man's friend's cell. The man's friend said this was unusual as the man had started staying in bed

during the mornings. They discussed why the man was wearing his orderly uniform as he had been suspended. The man's friend believed the man was disappointed about the suspension. The man's friend then went to work and when he came back around 11.30am, he and the man talked in the man's cell while they were waiting for lunch.

47. The officer had unlocked the man at about 11.25am for lunch. She told him that the person she needed to speak to about his job had been in a meeting that morning but she would try to find out more information that afternoon.
48. The man told the man's friend that he was really worried about the sentence he would receive for the new charges and his co-defendant had been bailed. The man said that if he got ten years [imprisonment], he could not do such a sentence. The man's friend tried to encourage him by saying that he would always be there for him no matter how long a sentence he got. They had to stop talking as they were already late collecting their lunch. The man's friend said he would see the man after lunch to which the man agreed. The man's friend told the investigator that in hindsight, the man had started to spend most of his time sleeping and his personal hygiene was beginning to slip.
49. The man's final telephone call was at 12.02 pm. His partner again confirmed that his co-defendant was no longer in prison. She then asked him if he had had a sexual relationship with another woman while he was on licence. The man firmly denied it but had to end the call as it was lunchtime. He said that he would call her again at 2.00pm. The officer overheard this conversation and said that the man seemed quite irate as he had raised his voice which was unusual. The man returned to his cell. The officer said he thanked her when she locked him in at 12.10pm.
50. The routine at lunchtime is that the prisoners collect their lunches and return to their cells to eat. They are locked in by about 12.15pm and there is a count of prisoners. The duty manager in charge of the regime (whose radio call sign is Oscar 1) collates the wings' totals. When it is correct, the staff have a one hour lunch break from around 12.30pm to 1.30pm, leaving a single officer on each wing. When they return from lunch, they unlock the prisoners for the afternoon activities.
51. On 6 January, the roll count was delayed by ten minutes. The duty manager was an SO and she told the investigator that at lunchtime, there had been an incident in which a prisoner had been fitting. She had dealt with this and it had delayed the count so the staff did not go to lunch until 12.40pm, returning at 1.40pm.
52. The officer began to unlock the cells on landings 1 and 2 before reaching the third landing. She unlocked the man's cell without looking through the observation panel and continued down the landing before returning to his door. She said it was unusual for him not to come out immediately so she went back. She pushed the door open and saw him suspended by a bed sheet from the door to the toilet. The man's back was against the door and he faced into the cell. The officer called "Code Blue" on the radio (to indicate an

emergency when a prisoner has breathing difficulties or restricted airways.) It was 1.55pm.

53. The officer ran out of the cell and called to a nearby prisoner, to come and help her. She went back into the cell and lifted the man up. The ligature was a sheet, thick and twisted and jammed over the top of the toilet door. The prisoner held the man up while the officer tried to open the toilet door but she was unable to do so as the sheet had wedged it tight. She went to the opposite side of the man and they both lifted him up higher to try to untie the knot in the sheet.
54. Another officer came in and tried, unsuccessfully, to open the toilet door. The officers had tried to use their cut-down tools which had proved impossible as the sheet was too thick. The SO then arrived with two prisoners. The SO and a prisoner managed to get the door open, which dislodged the sheet. Two officers and the other prisoner took the man's weight and laid him on the floor, on his back. The SO and another officer had also arrived by this time. The prisoners were asked to leave the cell.
55. The SO confirmed that an ambulance had been called and checked for breathing but found none. The officer did 30 chest compressions and then the SO used a mouth shield (obtained from the officer) and tried to give breaths. He was unable to get a seal on the shield and no air was going in to the man. The SO noted that the man's jaw was locked but continued to give breaths without the face mask and noticed that his chest rose and fell. However, he heard "gurgling" which he assumed meant there was fluid and debris in the lungs and airway and he could smell vomit. After another 30 chest compressions the officer left the cell and the other officer took over compressions. The SO then completed another two breaths but the presence of the man's vomit made it impossible to continue.
56. The duty emergency response nurse was in the healthcare centre when she heard the Code Blue on her radio. She and her colleague another nurse took the "grab bag" of basic emergency equipment and a defibrillator to the man's cell. (An automated external defibrillator or AED is a portable electronic device which measures electrical activity in the body and advises on action to be taken.) As the nurse entered the cell, the other nurse asked the SO to call the back-up healthcare team with the second emergency bag and checked an ambulance had been called, which was confirmed. The nurse estimated that the second team arrived at the man's cell within two minutes of hearing the emergency call.
57. The nurse tried to insert an airway into the man but could not and asked the SO to continue giving breaths while she prepared other equipment to clear the man's airway. The nurse tried to ventilate the man but could not so she used a face mask to put breaths into him. A nurse attached the defibrillator, which twice advised not to shock. This meant that there was no heartbeat for the machine to work on.

58. Once the nursing staff had taken over, the SO left the cell and ensured a member of staff had gone to the gate to meet the ambulance when it arrived. He instructed staff to continue to manage the other wings as normal. The healthcare manager called a doctor who arrived at 2.10pm and pronounced the man dead. Paramedics arrived at the man's cell at 2.13pm.
59. A prison manager was appointed as the prison's family liaison officer. Along with the Governor and the Reverend, she went to the home of the man's partner that afternoon to tell her about the man's death. Several of the man's family members were also there as they had already been made aware of his death by another relative at Hewell. The prison manager remained in contact with the man's partner and offered financial assistance with the funeral.
60. A hot debrief for healthcare staff was held at 3.00pm (this was separate from that held for discipline staff due to prison routine time constraints). A hot debrief is a meeting for staff to discuss issues and any lessons learned following serious events and emergencies, such as deaths in custody, hostage situations or escape attempts. The meeting should focus on reassurance, information sharing and how staff can support each other. During this meeting, staff commented that the emergency response bags were too bulky and heavy for one member of staff to carry without some assistance.
61. A second hot debrief was held for prison staff 45 minutes later. During this debrief it was suggested that a few inches be cut off the top of the toilet door to prevent them being jammed and create a safer environment for prisoners. Staff were offered the support of the care team and a critical incident debrief was also held.
62. Safer custody staff reviewed all prisoners subject to ACCT monitoring and asked the Samaritans to come to the prison to support the other Listeners. Two Samaritan volunteers arrived around 3.00pm and stayed for four hours, ensuring all the other Listeners had been told personally of the man's death. Those prisoners who had been involved in assisting the officer were offered specific support from the chaplaincy. An SO arranged to come into the prison specially the following day to ensure the Listeners felt adequately supported. All staff and prisoners who spoke to the investigator said that the man's death was a shock to them. He left no note to explain his actions.
63. The Listeners composed a written tribute to the man, with the assistance of a teacher in the education department. A manager collected the man's cellmate from work and broke the news to him privately. He was offered support and counselling advice, as was another prisoner who had been identified as a cousin of the man's. A well attended memorial service was held at the prison at which the Listeners' tribute was read out.

## ISSUES

### Clinical care

64. A clinical reviewer has provided a summary regarding his opinion of the man's clinical care with which we concur:

"I felt that both of the reception screens in the man's records were complete. On both occasions he was seen by a prison GP and appropriate referrals to the Mental Health services were made. In particular during the man's first stay at HMP Hewell there were concerns regarding his mental state immediately before his arrival there and in the subsequent weeks after his arrival. Medication was prescribed, consideration was given to the most appropriate place for him to reside, care plans were instigated as was an ACCT and early mental health assessments were made. There was evidence of good communication between community services and Healthcare, including records of mental health assessments from the community crisis care team and request for community records from his GP. There was appropriate escalation of his care and equally appropriate stepping down of his care and observations as his condition improved. The man stabilised on treatment during this first admission, he continued to engage with the mental health team, and was appropriately reviewed and discussed at the weekly MDT meetings. Prior to the man's release from HMP Hewell he was assessed, his anxieties were discussed and he was referred to the community services and take-home medications were prescribed.

"During the man's subsequent stay in HMP Hewell, he again had appropriate mental health referral and subsequent assessment. Medication was continued and prescribed, with antidepressants prescribed following subsequent assessment. He was initially assessed regarding his mental health and suicidal ideation but reviews and assessments were reduced as his mental health appeared stable.

"Latterly there was no record of face to face assessments but there was evidence that the man continued to be discussed at the MDT meetings. No concerns regarding his mental health were raised in the brief notes from these discussions."

### Emergency response

65. The man was discovered at 1.55pm. Immediately, assistance was requested from staff and prisoners nearby and by an emergency code called over the radio. They were at the cell within seconds and healthcare assistance arrived within two minutes. The SO was one of the first to arrive and administered breaths as part of cardiopulmonary resuscitation (CPR). When the face shield did not work, the SO continued to give breaths without one and ingested some vomit. After handing over to nurses, he ensured that the management of the situation and the wing was appropriate before considering his own

welfare. The SO is to be commended for his dedicated attempts to revive the man.

66. Overall, we agree with the clinical reviewer's conclusion that:

"The emergency procedures and the resuscitation attempts were implemented immediately on the discovery of the man hanging. CPR was commenced immediately, an ambulance was called. Healthcare staff attended with emergency equipment including a defibrillator promptly after the emergency call was raised. CPR was discontinued after clinical assessment."

67. During the hot debrief meetings following the man's death, staff said that the nurses' emergency bags were very heavy and bulky which made them difficult to carry and move about. We agree with the clinical reviewer's conclusion that:

"There is no evidence of any delay in the emergency equipment arriving so I have not made a formal recommendation but the Healthcare team may wish to review the contents and portability of the emergency bags and equipment."

68. Staff also suggested in one of these debriefs that a small amount from the top of the toilet doors in cells should be removed to prevent prisoners using it to hang themselves when jamming the door shut. While we recognise that it is not possible to remove ligature points from all cells, this appears to be a sensible suggestion to help avoid a similar situation in the future, particularly because of the difficulty in cutting the man down. An assessment would need to be made to ensure such an adaptation did not create a further hazard.

**The Governor should ensure, subject to a risk assessment, that adaptations are made to cell toilet doors to help avoid prisoners using the door as a point from which to hang themselves.**

69. Several prisoners were initially involved in the emergency response. The first was called by the officer who found the man to help assist her to remove the sheet which the man had used to hang himself. He helped by holding the man up. Two others arrived with the SO. One assisted with taking the man's weight, while the other helped to open the jammed toilet door. It is unusual for prisoners to assist in this type of emergency. However, it is clear that the officer had first made an emergency call for staff and that removing the ligature was a priority. The prisoner was the closest person to hand. Similarly, the other two prisoners served a useful function in helping to bear the man's weight and forcing the door which a single officer had been unable to do as it had been wedged. The prisoners were asked to leave as soon as they managed to release the ligature from the door and played no part in the resuscitation. We are satisfied that requesting prisoner assistance was the quickest way of releasing the man and starting the resuscitation process. The prisoners' actions were commendable.

## **The man's risk of suicide and self-harm**

70. The man had been subject to suicide and self-harm prevention monitoring under the ACCT procedures when he first arrived at Hewell on 24 December 2009. The procedures were reviewed and stopped the day after he was sentenced, on 14 May 2010. This review noted that he was "very happy" with the sentence he received as it meant that he should have less than six months to serve. He was not subject to ACCT monitoring again before his death.
71. In mid-November 2011, an officer noted that the man's mood seemed to have deteriorated and that he had suicidal thoughts. ACCT monitoring was not put in place but psychological therapy was considered and medication was prescribed. Subsequent entries show that he appeared to be in a better frame of mind. He was reviewed by a psychiatrist, staff considered his case during monthly MDT meetings and the nurses who dispensed the daily medication were tasked with "keeping an eye on him".
72. We consider that, at this point, staff should have considered opening an ACCT to give the man support as well as medical treatment. There is nothing in the records to indicate opening an ACCT was considered, despite the man's suicidal thoughts. In such circumstances, we accept that responses such as medication or other therapy might be more suitable than using the ACCT process but where staff decide not to open an ACCT, the decision and reasons for the decision should be noted in the prisoner's records.

### **The Governor and Head of Healthcare should ensure that when prisoners express thoughts of self-harm, staff record and explain decisions not to open an ACCT.**

73. The man trained as a Listener at the end of November and appeared to enjoy this work. He was also appointed as a reception orderly. On 3 January, he was suspended from this position pending enquiries. The following day he went to court, did not get bail and his case was listed for trial at a date to be arranged.
74. From a conversation with one of the man's friends in the prison, it appears that the man had been hopeful that, after his sentence expiry date for the original offence (24 December 2011), he might get bail. However, when he went to court on 4 January, he asked the reception manager about his job as a reception orderly suggesting he also believed he would probably return.
75. On 6 January, the man made three telephone calls to his partner during which she confirmed that his co-defendant had received bail the day before. It is apparent that the man thought this could mean it was more likely that he would be convicted and receive a lengthy sentence. The man's partner also asked if he had had an affair with another woman when he was on licence which he denied. He was upset during these telephone calls.

76. The man asked the officer about his suspension from his job as an orderly that morning. She said she would try and find out and let him know when she unlocked him for lunch. However, she was unable to do so and told him that she would try again that afternoon. The officer said he seemed “fine” about this. The man’s friend had spoken to the man before lunch who had told him he did not think he could cope with a ten year sentence. They agreed to talk more after lunch. However, the man was found hanging after the lunch period.

77. Staff, the man’s friend and the Samaritan volunteers interviewed were all shocked by the man’s death and none had believed he posed a risk of suicide or self-harm prior to his death.

78. The clinical reviewer concludes:

“The man was diagnosed by a psychiatrist whilst in HMP Hewell as having an emotionally unstable personality of borderline type. This emotional instability could make him prone to depression and the vulnerability of personality often making management of emotional distress dysfunctional, leading to a ‘vicious cycle’ of illicit substance misuse whilst in the community and to attempts at self harm.

In the days prior to his death, the man had concerns and anxieties regarding his pending court case and the possible future sentence. I believe that there were difficult telephone conversations between him and his partner regarding his possible sentence and their relationship. He also lost his job as a Reception Orderly in the few days before his death.

Due to his personality, emotional instability, I suspect that the combination of adverse stresses that he was experiencing, over which he had little or no control, contributed to the impulsive act which resulted in his death.

The man was well known to the Healthcare and Mental Health services, he had previously engaged the services and was aware how to access them. He had had regular reviews and been fully assessed and monitored. His mental state was perceived to be stable with no indication that he was planning suicide. Although a fellow prisoner felt that the man had been spending more time in bed and that his self-care had deteriorated in the few days prior to his death, there is no evidence that the man sought or attempted to access Healthcare or any other supportive service. Therefore I feel that his death could not reasonably have been foreseeable, anticipated or preventable.

In my opinion, the care that the man received in HMP Hewell was equivalent to the care he would have expected to have received in the community.”

79. We agree with the clinical reviewer’s view and assess the level of care which the man received as appropriate in relation to his risk of suicide and self-harm. Although staff did not implement the ACCT procedures when he

expressed thoughts of self-harm towards the end of 2011, we are satisfied that his mental health was appropriately monitored.

### **The man's work as a Listener**

80. The man completed his training as a Listener on 22 November and was regarded as in his probationary period when he died. The investigator had some concerns that, as the man had well-documented mental health issues including previous thoughts and acts of self-harm and suicide, he might not have been suitable to act in such a capacity. She therefore spoke to the staff who organised the selection and training of Listeners at Hewell, and the national co-ordinator.
81. An SO, the suicide prevention co-ordinator at Hewell, organises the Listener scheme at Hewell. The prison recruits Listeners every three months by advertising in the prison. Prisoners apply and the security and probation departments, their personal officer and potentially the wing senior officer complete checks on their suitability. The SO also reviews the prisoner's case notes for anything which would make them unsuitable for the role, for example if they have recently been subject to ACCT monitoring.
82. If a prisoner is deemed suitable for interview, the SO forwards their name to the Samaritans who conduct the interviews and advise the prison which prisoners are suitable for the role. Each Listener attends an open day when they would be interviewed. A successful prisoner then attends three days of training followed by a probationary period of three months when he can decide if the role is right for him. They are mentored by more experienced Listeners and attend any requests by a prisoner for a pair of Listeners.
83. At any point, a Listener can ask to be removed from the rota for a period if he feels overloaded or for personal reasons, such as an impending court case. They can also withdraw completely if they decide the role is not suited to them. Listeners also have 24 hour telephone support from the Samaritans should they need it and weekly group sessions for Listeners, with the Samaritans, are held in the prison chapel.
84. The National Prison Support Co-ordinator for the Samaritans, agreed that the selection and training process at Hewell is in accord with national guidance. The man was nearing the end of his three month probationary period and no-one had expressed any doubts about his ability to cope with the demands of the role.
85. While there is no suggestion that the man was not capable of carrying out his role as a Listener, we have concerns that healthcare staff are not among the group of people consulted when a prisoner applies to be a Listener. The clinical reviewer concluded that there may be occasions where a medical opinion might be helpful but that current procedures are "robust, flexible and supportive".

86. We agree but consider that some prisoners should have a health check to consider their suitability for the role. This should be done at the same time as the security department is consulted. While it appears that the man was well supported in his role, it would be preferable for a doctor to make an assessment of suitability to ensure that the role of Listener does not damage an individual's health or increase anxiety. We make the following recommendation:

**The Governor should ensure that, when appropriate, prisoners applying to be Listeners have a medical assessment to evaluate their suitability for the Listener role.**

#### **The man's suspension from his job as a reception orderly**

87. The man was given a job as a reception orderly, probably in December 2011 but the prison were unable to give an exact date. The reception manager suspended him on 3 January while he investigated staff concerns, which were not apparently based on any current issues about how the man was carrying out his job. The reception manager spoke to the man the following day when he was in reception waiting to go to court and said he was still looking into it but would let him know by the following day.
88. Unfortunately, the information the reception manager required was not easily accessible in the man's case notes and he was therefore still in the process of investigating the matter when the man died. The reception manager told the investigator that, when he spoke to the man on 4 January about the suspension, he did not seem unduly concerned about it, but his questions about what was happening would suggest otherwise. The SO said he was intending to conclude his investigation on 6 January.
89. Information about the man's suspension from his role as an orderly was not recorded in his case notes. It is important that such information is recorded in a prisoner's case notes for all staff to share. His work as a reception orderly allowed the man to be out of cell and working for most of the day. We are unable to determine the extent to which the suspension and consequent increase in time spent in his cell might have impacted on his psychological wellbeing, but it is clear that he asked staff about the position on more than one occasion. Because of the lack of information we are unable to form a view about whether the decision to suspend him was reasonable but the facts provided do not suggest there was sufficient information to support a suspension.

**The Governor should ensure that all information relevant to a prisoner's circumstances is recorded prisoner's case P-Nomis case notes.**

## CONCLUSION

90. The man had a history of substance misuse, mental health issues and suicidal feelings before his remand into prison in December 2009. He received treatment for these issues in prison and was monitored under the suicide and self-harm prevention procedures until May 2010. He successfully complied with his licence for eight months, following his release from prison in December 2010 but was returned to prison because of further serious charges in August 2011.
91. During this latter period in prison, he started work as a Listener and as a reception orderly. Both were jobs which he appeared to enjoy and his orderly role occupied him for most of the day. A prison officer and prisoner commented that towards the end of the year, the man's mood seemed to deteriorate, his personal hygiene slipped and he spent more time in bed. However, the man did not voice any concerns to staff.
92. It was only after his death, in listening to his recorded telephone calls and speaking to a fellow prisoner, that the depth of the man's concerns became apparent. When coupled with the mental health issues which the man experienced, we conclude it is highly likely that these factors contributed to his apparent suicide on 6 January 2012. However, his death came as a shock to staff and prisoners alike. The man had been a popular prisoner whose memorial service reflected this.

## **RECOMMENDATIONS**

1. The Governor should ensure, subject to a risk assessment, that adaptations are made to cell toilet doors to help avoid prisoners using the door as a point from which to hang themselves.
2. The Governor and Head of Healthcare should ensure that when prisoners express thoughts of self-harm, staff record and explain decisions not to open an ACCT.
3. The Governor should ensure that, when appropriate, prisoners applying to be Listeners have a medical assessment to evaluate their suitability for the Listener role.
4. The Governor should ensure that all information relevant to a prisoner's circumstances is recorded prisoner's case P-Nomis case notes.

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure, subject to a risk assessment, that adaptations are made to cell toilet doors to help avoid prisoners using the door as a point from which to hang themselves.	Accepted	A trial period will take place in which shortened toilet doors will be deployed within the prison.	November 2012.	
2	The Governor and Head of Healthcare should ensure that when prisoners express thoughts of self-harm, staff record and explain decisions not to open an ACCT.	Accepted	The requirement to record and explain decisions not to open an ACCT after a prisoner has expressed thoughts of self-harm is included within safer custody policy and guidance, which is made available to all staff.	In place.	
3	<p>The Governor should ensure that prisoners applying to be Listeners have a medical assessment to evaluate their suitability for the Listener role.</p> <p><b><i>After consultation with NOMS and the Samaritans National Prison Coordinator, this has been amended to, "The Governor should ensure that, when appropriate, prisoners applying to be Listeners have a medical assessment to evaluate their suitability for the Listener role."</i></b></p>				
4	The Governor should ensure that all information relevant to a prisoner's circumstances is	Accepted	It is not always possible to record all security information onto Prison-NOMIS. However, a system will be put in place to ensure that all other relevant	December 2012.	

	recorded prisoner's case P-Nomis case notes.		information is recorded on Prison-NOMIS – with management checks to be implemented to ensure compliance.  Notices have been published to remind staff of the importance of submitting information onto Prison-NOMIS case notes.		
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