



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in August 2014,
while a prisoner at HMP Peterborough**

Our Vision

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

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Peterborough on 27 August and died in hospital the next day. I offer my condolences to his family and friends.

One of our investigators carried out the investigation. A clinical reviewer reviewed the man's clinical care in prison. Peterborough cooperated fully with the investigation.

The man had been remanded to prison in December 2013 and had been in HMP Peterborough since 21 February. He had been in prison many times before and had attempted suicide in the past. He said that he had constant thoughts of suicide and would kill himself one day. Staff at Peterborough managed the man under Prison Service suicide and self-harm prevention procedures from June until he died.

An officer found the man hanging in his cell late at night on 27 August. Earlier that day, a psychiatrist had assessed him to see if he was suitable for admission to a specialist personality disorder unit. The man was apprehensive about the outcome and staff at the prison believed that his risk of suicide would increase if the hospital did not offer him a place for treatment, but they did not consider that the assessment itself had upset him. They did not review his level of risk after the assessment and staff continued to check him twice an hour.

The investigation found that the Prison Service's prescriptive procedures for managing prisoners at risk of suicide and self-harm were not always strictly followed and there were also some serious flaws in the prison's emergency response. However, the man had a constant and high underlying risk of suicide, which made it very difficult to manage him safely. While I consider that some judgements about the man's immediate level of risk could have been better, sadly, it is very difficult to prevent a person who makes a determined decision to kill himself from doing so. Overall, I am satisfied that staff at Peterborough made good efforts to try to safeguard the man, even if ultimately, those efforts failed.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man had a history of suicide attempts, mental health problems and substance misuse. He had served a number of prison sentences. In December 2013, he was remanded to HMP Belmarsh and staff immediately began Prison Service suicide and self-harm prevention procedures, known as ACCT. The man said that he had constant thoughts of suicide. In February 2014, he transferred to HMP Peterborough. After three days at the prison, staff ended the ACCT monitoring.
2. The man began to work with the prison psychologist, and psychiatrists assessed him. He continued to report having constant suicidal thoughts but staff did not open an ACCT again until June, when he said that he had practised taking his life.
3. Mental health staff thought that the man might benefit from treatment in a specialist personality disorder unit and, in June, referred him for assessment. The man was positive about the referral but still maintained that he would kill himself one day. Staff continued to manage him under ACCT procedures. At the end of July, staff constantly supervised the man for a period after he cut himself with a razor blade.
4. On Wednesday 27 August, a psychiatrist from a medium secure mental hospital assessed the man's suitability for a specialist unit. The assessment seemed to go well and the psychiatrist told the man that he would learn the result the next Monday. Staff who saw the man after the assessment had no particular concerns about him, although the man said that he was worried about the reality of hospital treatment, which he had never had before. Staff did not hold an ACCT review to re-assess his level of risk of suicide after the assessment, but thought that his risk would increase if he were subsequently found to be unsuitable for hospital treatment.
5. As part of the ACCT procedures, staff checked the man twice an hour. At 10.24pm, an officer found him hanging in his cell and raised the alarm. Prison staff and paramedics managed to regain the man's pulse but, sadly, he died in hospital the next day.
6. We have concerns about some aspects of the suicide and self-harm monitoring procedures at Peterborough. Staff did not follow national instructions about when to begin and end monitoring, did not risk assess the items that the man had access to and did not hold an ACCT review after the hospital assessment. However, we acknowledge that staff tried to support the man, who made plain his intention to kill himself one day. When the man was found hanging, staff did not follow emergency response procedures in line with local and national instructions. We make two recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and inviting anyone with information to contact him. No one responded.
8. The investigator obtained all relevant documents relating to the man's time in prison. He interviewed 17 members of staff at Peterborough and informed the Director of his preliminary findings.
9. NHS England appointed a clinical reviewer to review the clinical care the man received at Peterborough. The clinical reviewer joined the investigator for interviews with healthcare staff.
10. We informed HM Coroner for Peterborough of the investigation and we have sent him a copy of this report.
11. One of the Ombudsman's family liaison officers contacted the man's brother to inform him of the investigation and to invite him to identify any relevant issues that he wanted the investigation to consider. The man's brother wanted to know how frequently staff observed the man under ACCT procedures and whether the man had discussed his intentions with any other prisoners.
12. The man's family received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft report and the response to the recommendations has been added to the end of the report.

HMP PETERBOROUGH

13. HMP Peterborough is privately operated by Sodexo Justice Services. It holds both men and women in separate sides of the prison and has 24-hour health care provision. Cambridge and Peterborough NHS Foundation Trust provide mental health services at the prison.

Her Majesty's Inspectorate of Prisons

14. HM Inspectorate of Prisons (HMIP) last inspected the men's side of Peterborough in April 2011. Inspectors found that measures to support prisoners at risk of suicide and self-harm were very good. Assessment, care in custody and teamwork (ACCT) documents were generally of a high standard with good support from mental health services during reviews.
15. HMIP noted that the prison used enhanced case reviews and single point referral meetings effectively to provide additional multidisciplinary support for men with complex needs. Inspectors found that mental health services were very good but there were no day care services for prisoners with mental health problems who found it difficult to cope on the wings. When necessary, prisoners usually transferred to secure mental health units within four weeks.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. The IMB annual report for 2013/14 noted that the combined primary and secondary mental health teams were working well together. They reported good communication between staff, especially those dealing with prisoners with complex needs. The IMB noted that the quality of ACCT procedures had improved.

Previous deaths

17. The man's death was the fourth death at the men's side of Peterborough since 2012. We criticised some aspects of ACCT procedures in a case we investigated in 2012 and, more recently, in an investigation into the self-inflicted death of a woman at Peterborough.

Assessment, care in custody and teamwork (ACCT)

18. ACCT - assessment, care in custody and teamwork - is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

19. The man, had numerous convictions and had spent most of his adult life in prison. He had a history of drug misuse and said that he had begun to harm himself at an early age. He had attempted suicide, in and out of prison. In 2009, he tried to kill himself by taking an overdose of paracetamol and heroin. Later that year, he cut his neck with a razor blade. In 2013, he took another paracetamol overdose. In prison, staff frequently monitored the man under ACCT suicide and self-harm prevention procedures.
20. In 2010, while in prison, a psychiatrist diagnosed the man with an emotionally unstable and antisocial personality disorder, and referred him to a personality disorder unit, but he did not receive treatment. In 2002, the man spent some time in prison therapeutic communities at HMP Grendon and HMP Dovegate. He left both times, because he said that he could not trust the staff and because he had begun using heroin again.
21. The man was released from a prison sentence in May 2013. On 16 December 2013, he was, remanded to HMP Belmarsh charged with burglary. He told healthcare staff that he had used drugs for 30 years and felt depressed, hopeless and anxious. He said he thought constantly about suicide.
22. Prison doctors prescribed the man methadone (a heroin substitute), diazepam for anxiety and pregabalin for back pain. Healthcare staff noted the man's diagnosis of personality disorder (which is usually treated with psychological therapies rather than medication). They recorded that he had previously often asked for medication that he did not need.
23. Reception staff identified the man as at risk of suicide and self-harm and opened an ACCT the day he arrived. At frequent ACCT reviews, staff noted that the man preferred his own company and often said he would kill himself one day. He said that his Buddhist faith helped him to cope with his suicidal thoughts. Over the course of his time at Belmarsh, staff made five entries on the ACCT caremap, which is designed to identify the most pressing problems a person at risk is facing and set achievable goals to help reduce their risk. The caremap actions were:
 - That the man did not like to be around people and that it was up to him how much he chose to mix with other prisoners.
 - That the prison doctors needed to sort out the man's medication and that this was an ongoing issue.
 - That the mental health team needed to assess the man's mental health problems, which, in February 2014, was marked as outstanding as the man was still waiting for an appointment.
 - The man said that he would like to use the prison library and officers told him to go on the same days as new prisoners.

HMP Peterborough

24. On 21 February 2014, the man moved to HMP Peterborough, because of overcrowding at Belmarsh. The documents that accompanied him from Belmarsh to Peterborough contained information that the man often concealed razor blades (sometimes in his rectum). He would not give them any information about his next of kin.
25. The man told the reception nurse that he thought about suicide and harming himself all the time. He said that he used illicitly obtained prescription drugs in prison as well as his prescribed methadone. A prison doctor, Dr A, examined the man in reception and continued his prescriptions for methadone, diazepam and pregabalin. The doctor also noted the man's reported habit of asking doctors to prescribe medication he did not need.
26. At an ACCT review that afternoon, the man told staff that he suffered from depression and felt low all the time. He said the ACCT process was a waste of time and that he did not want to be on it or need any help. Staff referred the man to the mental health in-reach team, but the next day, he signed a disclaimer, saying that he did not want to engage with them. The man said that he was too cowardly to kill himself but that if he felt very low, he might be able to. Staff were required to check the man once an hour.
27. On 24 February, a senior prison custody officer (SO) A did another case review, with the man and an officer present. The man said that he had no thoughts of self-harm and asked staff to close the ACCT. The SO wrote that the man had a doctor's appointment that day to discuss a referral to the mental health in-reach team. He noted this on the ACCT caremap. The other entries remained marked as ongoing. The SO and the officer noted that the man had engaged well during the review. They concluded that he was a low risk of suicide and self-harm and closed the ACCT.
28. The man spent his first three weeks at Peterborough on the prison's first night and induction wing. On 13 March, he refused to move to one of the prison's main wings. Staff did not record the reason. The next day, he was found guilty of disobeying a lawful order and received a punishment of cellular confinement in the prison's segregation unit. Dr A examined the man before he moved to the segregation unit and thought that he looked jaundiced. The doctor admitted the man to the prison's inpatients unit for tests and monitoring. Blood tests showed that the man had an abnormal liver function. The doctor stopped the prescription for pregabalin noting that it could cause further liver problems.
29. On 18 March, the man tested positive for hepatitis B and C (viruses that infect the liver). Dr A referred the man to a liver specialist at Peterborough City Hospital. The doctor prescribed dosulepin for pain relief. The man remained under the hospital's care for hepatitis until his death. He had frequent appointments at the hospital and nurses tested his blood to monitor his liver function. Healthcare staff told the man that, because of the hepatitis, he could not take some medications, including some antidepressant and antipsychotic

medications.

30. On 21 March, the man, was sentenced to four years in prison for burglary and the possession of a bladed weapon. (Additional charges of robbery and firearm offences were referred to be heard at Basildon Crown Court on 12 September, two weeks after his death.)
31. On 24 March, the man told Dr A that he was feeling paranoid, that he could read people's thoughts and wanted to kill himself. The doctor told the investigator that the man was very clear that he would kill himself when the time was right. The doctor referred the man to the mental health in-reach team, but did not begin ACCT procedures, despite his apparent clear suicidal intent.
32. Throughout March and April, staff described the man as well behaved and polite. He usually complied with his healthcare plans and was medicated to ease his anxieties. Sometimes, he refused to take his medication as prescribed. He told staff that he was fed up being an inpatient, but understood why he was there.
33. On 2 April, the man told a mental health nurse, nurse A who was assessing him, that he had feelings of paranoia, hallucinations, depression, poor attention span and thoughts of self-harm. However, he said that he had no plans to put his thoughts into action at the time. The man said he had committed crimes as a cry for help and that he had previously tried to get admitted to hospital without success. The man said that he had suicidal thoughts every day and would take an overdose if he could get hold of tablets. The nurse did not open an ACCT. After the nurse's assessment, the mental health in-reach team decided that the man should see the prison psychiatrist.
34. On 11 April, Dr B, the prison's consultant psychiatrist, assessed the man and noted his history of constant suicidal thoughts, anger and paranoia. The doctor concluded that the man did not have a psychotic illness, but he was emotionally unstable and had a severe antisocial personality disorder. The psychiatrist noted that the GP should slowly reduce the prescribed diazepam dose and wrote that the man might benefit from antidepressant medication, as long as it did not affect his hepatitis. On 24 April, the man decided to stop taking diazepam. There is no record that doctors prescribed antidepressant medication.
35. On 7 May, the prison's clinical psychologist introduced herself to the man and arranged six further sessions. The man described his ongoing feelings of low mood and depression. He told her that the frequency of his suicidal thoughts was increasing. He said that he had no immediate plans to end his life but that it was only a matter of time. The man told her that he had concealed a razor blade for this purpose. The prison's clinical psychologist did not open an ACCT.
36. The prison's clinical psychologist told the investigator that she recommended to staff in the inpatients unit that the man should move cells from time to time to disrupt any suicidal plans he might have formed. At this time, the man often said that he had concealed razor blades in his rectum. He handed over blades to staff several times. (It is not clear where the man was getting the razor blades from. Officers told the investigator that prisoners in the inpatient unit had only

supervised access to razors. However, the man worked as a unit cleaner, which might have given him access to stores.)

37. On 15 May, the prison's clinical psychologist and the man met again and discussed his increasing despair. The man told her that his thoughts of suicide were more frequent, but he had no specific plan to kill himself. The prison's clinical psychologist noted that the man had few positive factors in his life. She told him that she would complete a suicide and self-harm risk assessment. The prison's clinical psychologist discussed her meeting with Dr A. They agreed that healthcare staff should continue to monitor the man for increasing signs of risk and hopelessness, but that an ACCT was not appropriate because it might increase the man's paranoia. She recorded this in the man's medical record.
38. On 23 May, the man told the prison's clinical psychologist about his ongoing low mood. She noted that he talked rationally and without fear about his death. She told the investigator that the man posed a chronic suicide risk. The man said that he would like to move to a personality disorder unit, as he had never tried this kind of treatment before. The man said that he did not have the means to kill himself as he could not get hold of enough paracetamol tablets and there were no ligature points in his cell. (The man was not in a designated safer cell with reduced ligature points but cells in the inpatients unit at Peterborough have few obvious ligature points.) The man said that he knew Dr A was trying to help him.
39. After the meeting, the prison's clinical psychologist and Dr A again agreed that monitoring the man under ACCT procedures was not necessary. The prison's clinical psychologist made an entry in the medical record detailing her meeting with the man.
40. On 28 May, the man finished his methadone detoxification. Dr A prescribed fentanyl (an opioid painkiller) patches for the man's back pain instead.
41. On 6 June, the prison's clinical psychologist saw the man again and noted that he had asked for more medication, which the doctor did not think he needed and which he could not take because he had hepatitis. The man said that he would consider suicide if he was not prescribed the medication he wanted. He told her that he had dissolved his fentanyl patch in water and then drunk the water. She told the man that this was dangerous and that Dr A would have to reconsider prescribing the patches. (The man continued to receive the patches for another month.) The man told the prison's clinical psychologist that he had practised killing himself over the weekend, by placing a bag over his head. He said he could not tolerate life as it was. The prison's clinical psychologist completed the suicide and self-harm risk assessment and assessed the man as at high risk of suicide.
42. The prison's clinical psychologist considered that the man's actions showed he was at increased risk of suicide and opened an ACCT. At the subsequent ACCT assessment interview and review, later that day, the man said that being on an ACCT was a waste of time and would not save his life. He said that he would work out how often staff were checking him so that he could kill himself between

checks. He told staff that his family was dead and that no one would care if he died.

43. The clinical nurse manager, A, chaired the first ACCT case review with Officer A. The clinical nurse manager and Officer A assessed the man's risk of suicide as raised and instructed staff to check him three times every hour. The clinical nurse manager made two entries in the man's ACCT caremap. The first was that he needed to see the doctor to discuss medication for his back pain and depression. The second was that he needed further assessment by a psychiatrist. The triggers section of the ACCT contained four entries: 'hopelessness', 'concerns about physical health' (which was later crossed out), 'change/unbalance' and 'PDU (personality disorder unit) allocation'. (It seems that the last two entries were added later.)
44. On 9 June, Nurse B chaired an ACCT review, with a member of the mental health in-reach team and an officer. She noted that the man was difficult to engage and would not say whether he was thinking of suicide. His assessed level of risk and the frequency of the checks remained unchanged. The nurse did not add anything to the caremap.
45. On 11 June, Dr C, a locum consultant psychiatrist, assessed the man, who said he was unhappy with his life and described feeling empty and emotionless. The man told the doctor about his constant suicidal thoughts. The doctor noted that the man had not benefited from antidepressants or antipsychotic medication, and that, in any case, he could not take them now because of his liver complaint. The doctor concluded that the man would remain a high suicide risk unless he believed that his life could be better. She wrote that he was an intelligent man who had accepted his diagnosis of personality disorder and was likely to benefit from an intensive programme of psychotherapy in a specialist personality disorder unit.
46. Dr C drafted a letter to the Secure Mental Health Services at South Essex Partnership University/NHS Foundation Trust (SEPT), asking the Trust to assess the man for admission to a specialist unit. On 13 June, the prison's clinical psychologist told the man that she had faxed Dr C's referral to Brockfield House, a medium secure psychiatric hospital in Essex. Brockfield House did not have a specialist personality disorder unit, but hospital staff were responsible for deciding whether to assess the man and which hospital might be most suitable for him. The man said that he was happy and hopeful for the future.
47. Between 13 June and 18 July, the man stayed in the inpatients unit and attended weekly ACCT reviews. Generally, either Nurse B or the prison's clinical psychologist chaired the reviews, and both prison and healthcare staff attended, including the prison's clinical psychologist and Dr A on occasions. No new entries were made on the ACCT caremap. On 13 June, the staff decided to reduce the frequency of observations to once an hour during periods of unlock and twice an hour when the man was locked in his cell. Staff were expected to record at least two conversations with the man each day.

48. On 17 June, the prison's clinical psychologist and the man discussed his referral. He said that he had no current thoughts of killing himself and was hoping to be admitted to a personality disorder unit for treatment. The prison's clinical psychologist noted in his medical record that she was worried that the man's risk of suicide would increase if he were not found suitable for hospital treatment. She did not update the triggers section of the ACCT.
49. Later that day, the prison's clinical psychologist spoke to Dr D, a psychiatrist at Brockfield House. The prison's clinical psychologist told the doctor about the man's risk, including his calm attitude towards suicide and increasing hopelessness. The prison's clinical psychologist kept the man informed about the progress of the referral and noted that he had realistic expectations and understood that the process would take time.
50. On 4 July, at an ACCT review with Nurse B and Officer B, the man said that he was feeling much better but that his mood would always be changeable. The staff reduced his observations to one every two hours during periods of unlock but maintained them at twice an hour when the man was locked in his cell.
51. On the evening of 17 July, the man threw his television at his cell door and threatened to assault a nurse because he did not want to wait for his medication. The man showed Officer C a razor blade he said he had been concealing in his rectum and said that he would use it to cut himself. The officer tried to persuade the man to hand over the razor blade, but he refused. Despite the man's threat to cut himself, no one reviewed the level of observations, which remained unchanged at twice an hour during the night. Night staff raised no further concerns about the man that night.
52. On 18 July, the man was charged with and found guilty of damaging his television. Because of the man's mental health, the prison Director allowed the man to have another television and to continue working as a cleaner.
53. SO B chaired an ACCT review that evening, with Dr A and an officer from the inpatients unit. The man told the staff that he planned to discharge himself from healthcare and return to a standard prison wing so that he could kill himself. The review panel increased the frequency of observations to once an hour during the day. They remained at twice an hour at night.
54. At 3.15pm on 22 July, the man said that he wanted to discharge himself from the inpatients unit. Just after 4.00pm, a senior nurse, C, talked to the man about this, but the man refused to discuss his plans and signed a disclaimer recording that he knew he was acting against medical advice. He was taken to Houseblock 3 later that afternoon. There is no evidence of any discussion between inpatients unit staff and the houseblock staff before the man moved.
55. At 6.00pm on Houseblock 3, SO A and Officer D held an ACCT review with the man. There were no healthcare staff present although he had been an inpatient since 13 March. The man told the officers that he had moved to the houseblock because he would be able to kill himself more easily. The SO discussed the man with a senior manager who agreed that the man should return to the inpatients

unit, which he did shortly after the review. The SO increased the required frequency of checks to twice an hour at all times, with three recorded conversations with the man each day.

56. On 23 July, the head of the mental health in-reach team chased Brockfield House for information about the man's assessment but no one was available. On 25 July, the prison clinical psychologist told the man that staff at Brockfield House would discuss his referral at a meeting on 28 July. She noted that the man was anxious about the referral. The man told her that he still had thoughts of suicide and a plan to kill himself. He said that if Brockfield House did not agree to assess him, he would try to end his life. She noted in his medical record that the prison would need to manage the man's risk carefully through the ACCT process if Brockfield House decided not to assess him.
57. On 28 July, an operational healthcare manager, chaired an ACCT review. The prison's clinical psychologist, Nurse B and Officer E also attended. The man engaged well and said that he was managing his constant thoughts of self-harm by meditation and tai chi. The panel reduced the man's observations to one every two hours and assessed him as low risk. The operational healthcare manager made three entries in the ACCT caremap; she noted that they were still waiting to hear from Brockfield House, that the man's suicidal thoughts worsened during times of change, and that he needed to be kept busy and to meditate.
58. That afternoon, Dr D phoned the healthcare department and said that the man did not meet the criteria for assessment. The doctor sent a written explanation, which arrived on 30 July. She had concluded that the prison could manage the man's risk of suicide through psychological interventions or prison programmes. At 5.00pm, the prison's clinical psychologist told the man and said that she would ask Dr D, one of the prison's locum psychiatrists, to reassess him with a view to referring him for a further assessment. The man said that he knew Brockfield House would not agree to assess him. She asked if he was thinking of harming himself and he said 'no comment.'
59. At 5.15pm, the operational healthcare manager chaired another ACCT review with the prison's clinical psychologist, the head of the mental health in-reach team, Nurse B and Officer E. They decided that, because of the news the man had received, his risk of self-harm had increased and raised the frequency of observations to four an hour. The operational healthcare manager wrote in the caremap that the prison's clinical psychologist was arranging another psychiatric assessment so that they could challenge the decision not to assess him for a personality disorder unit.
60. At around 8.30pm, the man cut his neck with a razor blade. He refused treatment or to hand over the blade. The man said he would conceal the blade in his rectum to prevent staff from getting it. However, he later gave a blade to a prison manager, and allowed the nurse to treat his wound.
61. At 9.15pm, the prison manager chaired another ACCT review, with two prison officers. The man said that he had self-harmed as a release from the day's events. The prison manager noted that the man seemed less frustrated and a lot

calmer. They agreed to maintain the man's observations at four an hour.

62. The next day, 29 July, the operational healthcare manager chaired an ACCT review, which the prison's clinical psychologist attended. The man refused to engage fully and asked to sign a disclaimer refusing mental health treatment, including with the prison's clinical psychologist. The man talked openly about wanting to die and said that no one would be able to stop him as he had a razor blade concealed in his rectum. The operational healthcare manager increased the frequency of observations to five an hour, which the man said he was unhappy about. The operational healthcare manager updated the man's caremap, noting that he had refused to engage and that staff would need to encourage and support him.
63. That afternoon, Dr D and the prison's clinical psychologist saw the man. They tried to talk to him about managing his problems but he said he was not interested. The man said that he would kill himself eventually. After the meeting, Dr D wrote to Brockfield House asking them to reconsider their decision.
64. On 30 July, the man told Officer F that, now Brockfield House had refused to assess him, he felt worse. He said that there was only one way out and that his head was 'starting to go', but he would not elaborate. He refused to hand over the razor blades he said he had concealed.
65. The operational healthcare manager chaired an ACCT review on 31 July, with Nurse D and Nurse B. Officer C and Dr A gave information in advance but did not attend. The review panel discussed the man's continued support from the mental health team and their efforts to persuade Brockfield House to reconsider assessing him. The man said that he would try to work with staff, but repeated that he was thinking about ways of killing himself. The man's frequency of observations remained at five an hour. The operational healthcare manager added three entries on the caremap:
 - To arrange a mental health review to discuss his progress;
 - To arrange an appointment with the optician for reading glasses;
 - For Dr A to review the man's medication and consider whether he could prescribe anything to help lift the man's mood.
66. Staff recorded that the man's mood changed later that afternoon when he became argumentative and threatened to stab Dr A and prison officers because he had received his diazepam late. The man told staff to prepare the control and restraint team.
67. At 9.15pm, the man cut his wrists and concealed the razor blades in his rectum and mouth. He would not allow Nurse E to treat the wounds and said he would continue cutting himself. At around 10.00pm, the man cut his wrist again and said that he wanted to die. The man smashed his television, threatened to harm staff and became verbally abusive.
68. SO C discussed the man with the duty manager who agreed that the man should be restrained so that he could not harm himself. Officers restrained the man and

moved him out of his cell while they searched it and removed items he could use to harm himself with. The man refused to allow Nurse E or Dr E, the duty doctor to treat him. The doctor prescribed a three-day course of clonazepam, a sedative, which the man could take at night to help him sleep. The SO asked the man to change into anti-rip clothing and gave him anti-rip bedding (which is made out of material that is extremely difficult to tear into strips to create ligatures). The man went back to his cell but refused to give staff the razor blades he said he had hidden internally. The SO did not hold a formal ACCT review, but he and the duty manager decided that the man should be constantly supervised (when a prisoner is watched at all times).

69. The next morning, 1 August, the man said that he was upset that officers had restrained him the previous evening and he would assault those involved. However, during the day he became more positive. He agreed to hand over the razor blade he had concealed in his rectum, but said he was unable to retrieve it.
70. The Deputy Head of Healthcare, the clinical nurse manager A, Dr A, the head of the mental health in-reach team and a prison officer held an ACCT review with the man at 3.10pm. They discussed the man's escalating self-harm and the man said that death was preferable to life, as it would relieve his emptiness. The man remained constantly supervised, but the panel agreed that he could wear his own clothes and returned other personal items to him. Dr A thought that the man was showing signs of sleep deprivation, which was increasing his depression and suicidal thoughts. The doctor agreed that clonazepam might help the man to sleep but that it could not be prescribed for very long as it could damage his liver.
71. On 2 August, prison manager, B, held another ACCT review, with one officer present. The deputy head of healthcare gave information in advance but did not attend. The man said that he felt empty inside and did not care if he lived or died, but that he still wanted hospital treatment. That evening the man handed a razor blade to officers. He said that he had found it on his cell floor and that it was a 'sign from above'.
72. Prison manager, B, a nurse from the mental health in-reach team and two prison officers met for another case review on 3 August. The man refused to attend and told staff that he would 'lose it' if they did not end the constant supervision. Prison manager, B, decided to maintain constant supervision until one of the man's regular ACCT case managers could chair a review the next day.
73. On 4 August, Dr D carried out a psychiatric assessment. The man told the psychiatrist that staff were lying to him, that he was borderline schizophrenic, and that his mind was in turmoil. Later that day, the head of the male prison, the operational healthcare manager, head of the mental health in-reach team, the clinical nurse manager and Dr D saw the man for an ACCT review. They decided that the man still needed to be constantly supervised. After the review, the man told an officer that he had concealed two razor blades, and that although he was not planning to use them, they were a comfort as it meant he could end his life at any time. (The next evening, the man handed the razor blades to staff.)

74. On 5 August, the head of the male prison chaired another multidisciplinary ACCT review. The man refused to engage with the ACCT process or the mental health in-reach team, including the prison's clinical psychologist. However, on 6 August, he went to an ACCT review chaired by the operational healthcare manager and attended by the head of the male prison and an officer. He said that he wanted to work with the prison's clinical psychologist again. The review panel decided to end the constant supervision but instructed staff to check him five times an hour.
75. On 8 August, Dr D assessed the man and then wrote to Dr D at Brockfield House. He reiterated that the man was a very high suicide risk, had been subject to constant supervision and often hid razor blades. Dr D explained that the mental health facilities at Peterborough could not meet the man's needs and strongly recommended that Dr D should reconsider the decision not to assess the man. Because of Dr D's letter, Brockfield House agreed to assess the man later that month.
76. At an ACCT review on 14 August, the man told the head of the male prison, the operational healthcare manager, Nurse B, Nurse F and the head of the mental health in-reach team that his mental health was deteriorating. He said that he was hallucinating and needed different medication. The review panel told him that his medication options were limited because of his liver problems. They noted that Brockfield House would assess the man soon and that, despite his feelings, he had said that his thoughts of suicide and self-harm had reduced. The panel reduced the frequency of observations to three an hour.
77. On 20 August, the operational healthcare manager chaired an ACCT review with the head of the male prison, the prison's clinical psychologist, a nurse and an officer. The operational healthcare manager noted that the man was unhappy that Brockfield House had postponed his assessment until the next week. The man said that he was in control of the voices telling him about death, and he had no thoughts of suicide or self-harm. The panel assessed his level of risk as low and reduced the frequency of observations to two an hour.
78. On 22 August, the man asked to see the prison's clinical psychologist and they talked about his forthcoming assessment for a personality disorder unit, which was due to take place on 27 August. She noted in the man's healthcare plan that he still had thoughts of suicide, but that the possibility of moving to a hospital seemed to be keeping him from acting on his thoughts. She wrote that this might change if he was assessed as unsuitable.
79. On 23 August, Dr E and the man talked about the assessment. Because the man was anxious about the outcome, the doctor agreed to prescribe another three night's of clonazepam to help him sleep.

Wednesday 27 August

80. The prison's clinical psychologist told the investigator that, at 9.45am on Wednesday 27 August, an officer phoned the mental health team and spoke to Nurse G. The officer asked whether the man's ACCT review (which was due that

day) should be held that morning and whether the prison's clinical psychologist could attend. The prison's clinical psychologist said that she was sitting opposite Nurse G at the time and advised her to tell the officer to arrange the ACCT review after his assessment for a personality disorder unit that afternoon, because it might unsettle the man. There is no record of this conversation in the man's ACCT or in his medical record. Until the investigator told her, the prison's clinical psychologist did not know that the review had gone ahead that morning, before the assessment.

81. At 11.50am, the operational healthcare manager chaired the man's ACCT review with an officer and a mental health nurse. The man said that he felt positive because he was having his assessment that afternoon. She told him that another ACCT review would take place the next Monday, 1 September, by which time they should know the outcome of the assessment. They agreed that staff should continue to check the man twice an hour. She told the investigator that she believed that the man's risk would increase if he were assessed as unsuitable for hospital treatment. She did not think that the assessment itself was likely to increase his risk and she did not think that she needed to increase the frequency of observations because of it.
82. That afternoon, the prison's clinical psychologist took the psychiatrist from Brockfield House, to the healthcare unit and gave her further information about the man. The psychiatrist finished the assessment at about 3.00pm and the man returned to the inpatients unit. The psychiatrist told the investigator that the man had engaged well during the assessment. She said that the man had asked her for feedback and she had told him that the referrals panel at Brockfield House would discuss her assessment and he would hear more the next Monday. The psychiatrist said that she told the man that, if they assessed him as suitable for treatment in a specialist personality disorder unit, his local health authority would need to fund his place at a suitable unit. She said that the man seemed quite happy at the end of their conversation.
83. The psychiatrist from Brockfield said that after the assessment, she talked to Nurse G (who was the duty mental health nurse) about the assessment and said that she had no serious concerns about the man. The psychiatrist looked through the man's medical record and told the nurse that the prison would receive feedback after the referrals meeting at Brockfield House. Nurse G made no note of her conversation with the psychiatrist in any of the man's records. The nurse escorted the psychiatrist out of the prison at around 4.00pm. On the way out, the psychiatrist briefly saw the prison's clinical psychologist and told her that the assessment had gone well.
84. After the assessment, the man told Officer F that he was in a 'dip' and that the last time he had felt this way, the doctor had prescribed medication to help him. The officer talked to the duty doctor (a locum) at the end of her rounds and told her that the man had asked for more medication. The prison's clinical psychologist, who was in the room at the time, told the doctor about the man's substance misuse history and that he often asked for more medication. She also said that the man might be anxious because he had just had an assessment for a personality disorder unit. The doctor checked the man's medical record but did

not see him in person. She decided not to prescribe any more medication.

85. The prison's clinical psychologist and the head of mental health in-reach team saw the man in the corridor as they left the unit for the day and the prison's clinical psychologist asked him how the assessment had gone. She said that the man told her that it had gone well and that Brockfield House would look for a personality disorder unit to take him. However, she said that the man seemed to be having doubts about going to hospital for treatment. The prison's clinical psychologist said that she asked the man if she needed to worry about him. The man told her that he was not depressed or suicidal, but needed to 'get his head around it.' The man agreed to talk to her in private the next morning. The prison's clinical psychologist said that the conversation did not worry her or make her think that he was planning to harm himself. She believed that he was content to discuss the assessment with her the next day.
86. Officer F locked the man in his cell and told him the doctor was reviewing his medication. Later, he and the nurse dispensed medications on the unit. The man asked if the doctor had prescribed him any extra medication and the nurse said not. The officer said that the man thanked them both and went back to watching his television.
87. At 7.45pm, Officer F handed over to Officer A. Officer F told him about the man's assessment and that he had said he was in a dip and had asked for more medication. Officer F told the investigator that he had no specific concerns about the man and thought that he was behaving normally.
88. At 10.03pm (all times are taken from the prison's CCTV footage which was approximately two minutes ahead of GMT), Officer A checked the man. The man was sitting on a chair in the middle of the cell, in darkness. The officer asked the man if he was okay and he replied angrily that he was meditating and did not want to be disturbed. The officer said that he apologised to the man and walked away.
89. Officer A checked the man again at 10.24pm and spent about 45 seconds looking through the observation hatch in the cell door. The officer said that, at first, he could not see the man, but then realised that he was hanging to the right of the door with a piece of torn sheet around his neck. The man had used a shelf bracket (which he must have taken from a supply cupboard in the inpatients unit) and had wedged this between the cell wall and his wardrobe. He had then tied the sheet to it. At 10.25pm, Officer A radioed a code blue (an emergency call sign, which signifies a life-threatening medical emergency, such as when a person is found hanging, unconscious or not breathing). Officer G, relayed the message to all staff in the prison, but did not call an ambulance immediately as emergency procedures require.
90. Officer A said that, as he radioed the emergency, he went to get Nurse E who was near by. Nurse E, had the emergency first aid bag with her (which contains basic first aid equipment), and she and Officer A went to the man's cell. Officer A said that he realised that he was not carrying his anti-ligature cut down tool,

which prison officers should carry at all times. He had forgotten to attach it to his belt when he came on duty, so he ran back to the unit office to get it.

91. At night, for security reason, officers on wings do not carry cell keys on their key chains but have a key in a sealed pouch for use in an emergency. Officer A said that he forgot that he had this key so he put his arm through the observation hatch in the man's cell door and cut the sheet from which the man was hanging. the man slumped to the floor.
92. A healthcare assistant and Officer H arrived at the cell. Officer A asked Officer H if he had a cell key but Officer H, whose job was to patrol the prison that night, was not carrying one. (Only officers based on the wings carry cell keys in sealed pouches.)
93. Officer I, SO C, Officer J, Officer K and Officer L all responded to the code blue call and went to the inpatients unit.
94. According to the CCTV footage, Officer I and SO C arrived at the man's cell at 10.27pm. Officer A told them that he had found the man hanging and that he had cut the ligature. Officer I looked through the observation hatch, used his emergency key and went into the cell. Nurse E and some of the other officers present followed him.
95. Officer I removed the material from the man's neck and he and Nurse E checked for signs of life, before starting cardiopulmonary resuscitation. Just after 10.27pm, Nurse E asked if an ambulance had been called. SO C then contacted Officer G in the control room who called one.
96. Nurse E asked the officers to bring additional emergency equipment from the unit office. (Neither Nurse E nor Officer A had gone to get this while they waited for other staff to arrive.) At 10.29pm, an officer passed a large resuscitation bag which contained an oxygen cylinder and a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) into the cell. Nurse E and the officers continued cardiopulmonary resuscitation.
97. The first response paramedic arrived at the cell at 10.43pm, followed two minutes later by others who had arrived in an ambulance. At about 10.52pm, the paramedics detected that the man had a pulse. Officers had asked Dr E, the on call doctor, to come to the prison and he arrived at 11.00pm. At 11.22pm, the paramedics decided that the man was stable enough to transfer to Peterborough City Hospital.
98. The man remained in a critical condition overnight. At 9.00am on 28 August, a hospital consultant decided that the life support machine should be switched off. The man died an hour later.

Support for staff and prisoners

99. At 6.40am on 28 August, the Director debriefed the staff involved in the emergency response. (This meeting gives staff involved in a traumatic incident

the opportunity to share their feelings and for managers to ensure they are offered appropriate support.) Those involved said that they found it helpful and that the prison's care and welfare team offered them good support.

100. Staff reviewed all prisoners being managed under ACCT procedures to check whether they had been affected by the man's death and to offer support.

Family Liaison

101. When he arrived at Peterborough and during the ACCT process, the man had refused to give details of any next of kin. The man had not made any phone calls since arriving at Peterborough and had not received any visits. The prison family liaison officer, eventually found a reference to the man's brothers in his probation file. The police liaison officer found an address for one of them and, at midday on 28 August, the prison liaison officer and a colleague, visited the man's brother at home and broke the news of the man's death. The prison offered funeral expenses in line with national policy.

Post-mortem report

102. A post-mortem examination concluded that the man's death was by hanging. Toxicology results revealed very low levels of sulphiride in the man's blood. (Sulpiride is mainly used in the treatment of psychosis associated with schizophrenia and other major depressive disorders.) The man was not prescribed sulphiride and we do not know how he obtained it. The clinical reviewer concluded that the man might have taken the medication some days before he died. The examination also detected other medications prescribed to the man at therapeutic levels.

ISSUES

Suicide and self-harm monitoring

Decisions to begin and end ACCT monitoring

103. When the man arrived at Peterborough from Belmarsh on 21 February, he was subject to ACCT procedures because of his frequent suicidal thoughts. Just the day before, he had said that he wanted to kill himself. He told the reception nurse at Peterborough that he had constant thoughts of suicide and self-harm. He had a history of substance misuse and mental health problems and had attempted suicide in the past. Transfer and early days at a new prison are also recognised risk factors for suicide. Despite these clear and documented risk factors, staff at Peterborough decided to close the ACCT on 24 February, when he had been at the prison for only three days.
104. Prison Service Instruction (PSI) 64/2011, which covers suicide and self-harm prevention, instructs that staff can only close an ACCT once all of the actions on the caremap have been completed and the review panel consider that it is safe to do so. Several of the entries on the man's ACCT caremap were still marked as ongoing when staff closed the ACCT on 24 February and had not been completed. The staff who closed the ACCT did not know the man and, despite his outstanding mental health issues, there was no healthcare presence at the review and no other multidisciplinary representation. Although some months passed before staff opened another ACCT, we consider that it the decision to close the ACCT in February was premature and not in line with national instructions.
105. We are concerned that on several occasions, members of primary healthcare and the mental health in-reach team did not open an ACCT in accordance with PSI 64/2011. The PSI contains a mandatory instruction that 'any member of staff who receives information or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT'. We consider that Dr A should have opened an ACCT on 24 March, Nurse G on 2 April and the prison's clinical psychologist or Dr A on 15 and 23 May. The prison's clinical psychologist finally opened the ACCT on 6 June, after the man said that he had practised taking his life by placing a bag over his head. Although the prison's clinical psychologist and Dr A recorded some details about their decision-making in the man's medical record, opening an ACCT to manage his risk would have alerted all staff in contact with him to his specific risks and triggers.

Discharge to houseblock 3

106. On the afternoon of 22 July, the man said that he wanted to discharge himself from the inpatients unit. He signed a disclaimer acknowledging that he was acting against medical advice and moved to Houseblock 3, a standard residential wing. We are surprised that staff allowed him to move. At an ACCT review on the houseblock that evening, the man told officers that he had moved to the wing in order to kill himself. Staff moved him back to the inpatients unit almost immediately.

107. PSI 64/2011 instructs that when a move from a healthcare unit is planned for a prisoner on an ACCT, a pre-discharge case review must take place before the prisoner moves. Staff from the receiving wing must be invited to ensure that relevant information and risk is shared. Although the man's discharge happened quickly and against clinical advice, we believe there was time for healthcare staff to convene an ACCT review and invite officers from Houseblock 3 to attend. We found no evidence in the man's ACCT plan or medical record that healthcare staff discussed his discharge with staff on Houseblock 3. The man had previously said that he would discharge himself to a wing so that he could kill himself and healthcare staff who knew him well must have had serious concerns about his motivation on this occasion.

Managing the man's access to items

108. The man had used a number of methods to harm himself in the past, including overdosing on medication and cutting himself with razor blades. In prison, he often hid razor blades in his rectum. Sometimes he said that just having them gave him comfort, but on 28 and 31 July, he used them to cut himself. The man handed various blades to staff but always seemed to have access to more. Officers told the investigator that prisoners in the inpatients unit had only supervised access to razor blades.
109. None of the man's ACCT reviews addressed where he was getting the blades from or what measures staff needed to take to restrict his access to items he could use to harm himself. The man had a trusted role as a unit cleaner and it is possible that this gave him unsupervised access to a number of items he could use to harm himself. When he hanged himself, he used a shelf bracket, which he had taken from a supply cupboard in the inpatients unit, as a ligature point.
110. PSI 64/2011 instructs that staff involved in ACCT reviews must agree the items that the prisoner is allowed to have. If the prisoner has or may have acquired items which they could use to harm themselves, and which have not been agreed, they must be searched and the items removed. Staff searched the man's cell and removed items only once. We consider that, given his high risk of suicide and self-harm, staff should have been more concerned about the man's access to items and ACCT reviews should have discussed how best to manage this risk.

Completion of the ACCT document

111. While The man was monitored on an ACCT, the frequency of observations changed several times. PSI 64/2011 stipulates that observations must be conducted at unpredictable intervals. The man said several times that he would work out how often staff checked him so that he could kill himself between checks. For that reason, it was particularly important that staff checked him at irregular intervals. We found that too often, particularly at night, staff recorded observations at regular and predictable intervals.

112. Four things were listed on the first page of the man's ACCT document, which deals with triggers and warning signs. These were, 'hopelessness', 'concerns about physical health' (which was later crossed out), 'change/unbalance' and 'PDU [personality disorder unit] allocation'.
113. PSI 64/2011 states that this section of the ACCT should list events or signs of increased risk that will be watched for and which trigger further action and /or an immediate case review. We do not think staff completed this section of the ACCT as the PSI intends. Two of the things that staff wrote about the man were not events that might happen to him, but background risk factors. The listed triggers were broad and unspecific, for example, the man said that he felt hopeless almost all of the time and it would not have been practical or sensible to hold a review each time he said that he felt this way. Once psychiatrists had referred the man to Brockfield House for assessment, the prison's clinical psychologist and other staff recorded that they were concerned his risk would increase significantly if the referral were unsuccessful. However, they did not clearly record this as a trigger as they should have done. The words 'PDU allocation' might have referred to the Brockfield House assessment but this was too unspecific to be helpful.

The timing of the last ACCT review on 27 August

114. On the morning of 27 August, an unidentified officer phoned the mental health team office to ask when the man's ACCT review, scheduled for that day, should take place and whether the prison's, clinical psychologist could attend. She said that she asked Nurse G to tell the officer that it should take place in the afternoon after the psychiatrist from Brockfield House had assessed him. She said that she suggested this because she thought that the man might be unsettled by the assessment. In fact, the review, chaired by the operational healthcare manager, took place in the morning, before the assessment. The prison's clinical psychologist was not aware and did not attend. As she had advised that the review should take place after the assessment, we are surprised that it was not held later that afternoon.
115. We recognise that staff had identified that the man would be at raised risk of suicide if Brockfield House assessed him as unsuitable for specialist treatment and that he gave them no specific reason to worry that afternoon. The psychiatrist who assessed him did not have any particular concerns at the end of the assessment, and said so to the prison's clinical psychologist and others. However, the prison's, clinical psychologist's original advice, that the review should be held after his assessment interview, seems to have been sensible. That way, staff, who did not know how the assessment might affect the man, could have checked his wellbeing, offered him support and considered increasing the frequency of checks. Nevertheless, there was little to indicate that the man was at imminent and acute risk of suicide that day.
116. Despite the issues identified, the man generally received good support through the ACCT process. Between 6 June and 27 August, the man had 26 case reviews, and only four of these were not multidisciplinary. On many occasions, the prison's clinical psychologist, Dr A and other staff who had frequent contact

with him attended. He had a number of different case managers, but in the last month, case management was consistent. Often, his ACCT reviews were chaired by senior prison managers which, because of his high risk and complex behaviour, was appropriate. The ACCT caremap was usually updated and the frequency of observations was raised and lowered according to the perceived level of risk.

117. The man always maintained that he would kill himself one day and therefore was always at risk. Ultimately, it is very difficult to prevent someone who makes a determined decision to kill himself from carrying out that plan, without making living conditions so restrictive as to be inhumane. Overall, we consider that staff at Peterborough made appropriate and reasonable efforts to manage the man's risk. Nevertheless, PSI 64/2011 notes that 'The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed'. The investigation identified a need for improvements in aspects of ACCT procedures outlined above. We make the following recommendation:

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

- **Not closing ACCTs until all identified actions on caremaps have been completed;**
- **Opening an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent;**
- **Ensuring that decisions about whether items should be removed from prisoners are discussed and recorded at ACCT case reviews;**
- **Carrying out ACCT observations at irregular intervals to prevent prisoners being able to predict when they will take place;**
- **Completing the triggers section of the ACCT document.**

Clinical care

118. The clinical reviewer concluded that the clinical care the man received at Peterborough was better than he might have expected in the community. The clinical reviewer noted that:

- Dr A admitted the man to the inpatients unit as soon as he considered that he looked jaundiced;
- Diagnoses were appropriate and prompt;
- Dr A promptly referred the man to liver specialists at the local hospital and he remained under their care until his death;
- Dr A prescribed appropriate medication, bearing in mind the man's liver condition;
- The man's methadone dose was reduced appropriately until the man no longer took any;
- The man had frequent contact with and assessments by mental health staff including psychiatrists; and
- The man's care plan was very good with frequent entries.

119. The clinical reviewer identified some areas for improvement in aspects of healthcare procedures, including record keeping and prescribing practice, which the Head of Healthcare will need to address. We do not repeat his recommendations in this report as they were not directly related to the circumstances of the man's death. The clinical reviewer also acknowledged some recent apparent improvement in mental health services at Peterborough.

Emergency response

120. We have a number of concerns about the emergency response on the night of 27 August. When Officer A found the man hanging he appropriately radioed a code blue. However, Officer G did not call an ambulance until SO C asked him to do so three minutes later. This was contrary to the national and local instruction, which requires this to be done immediately an emergency code is called. Officer G said that he knew he should have called an ambulance automatically and did not know why had not done so.
121. Officer A was not carrying his anti-ligature cut down tool and had to go back to the unit office for it. PSI 64/2011 instructs that all uniformed staff must carry their own personal issue anti-ligature cut down tool with them at all times. Officer A said that he had also forgotten that he had a cell key in a sealed pouch and so he did not immediately unlock the man's cell.
122. According to the CCTV footage, Officer I (who eventually unlocked the cell) arrived two minutes after the code blue call. Before then, Officer A had reached through the observation hatch in the cell door and cut the sheet from the shelf bracket, but not from around the man's neck. Neither Officer A nor Nurse E brought resuscitation equipment to the cell while they waited for other staff to arrive. An officer brought oxygen and a defibrillator at 10.29pm, after the cell had been unlocked, and five minutes after Officer A had raised the alarm.
123. We are particularly concerned about the accumulation of delays in the response to the man's hanging because the paramedics managed to restore his pulse before taking him to hospital. We cannot know whether a prompter, more effective response would have made any difference to the outcome for the man, but it was evident that the staff were unsure about their responsibilities. We make the following recommendation:

The Director and Head of Healthcare should make active efforts to ensure that all prison and healthcare staff are made aware of and understand their responsibilities during medical emergencies, including that staff:

- **Carry anti-ligature cut down tools at all times when they are on duty;**
- **Open cells as quickly as possible, using emergency keys at night, to administer basic life support;**
- **Bring relevant emergency first aid equipment immediately to a code blue; and**
- **Call an ambulance as soon as a code blue alarm is made.**

RECOMMENDATIONS

1. The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Not closing ACCTs until all identified actions on caremaps have been completed;
 - Opening an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent;
 - Ensuring that decisions about whether items should be removed from prisoners are discussed and recorded at ACCT case reviews;
 - Carrying out ACCT observations at irregular intervals to prevent prisoners being able to predict when they will take place;
 - Completing the triggers section of the ACCT document.

2. The Director and Head of Healthcare should make active efforts to ensure that all prison and healthcare staff are made aware of and understand their responsibilities during medical emergencies, including that staff:
 - Carry anti-ligature cut down tools at all times when they are on duty;
 - Open cells as quickly as possible, using emergency keys at night, to administer basic life support;
 - Bring relevant emergency first aid equipment immediately to a code blue; and
 - Call an ambulance as soon as a code blue alarm is made.

Action Plan: The man – HMP Peterborough on 28/8/14

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> • Not closing ACCTs until all identified actions on care maps have been completed; • Opening an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent; • Ensuring that decisions about whether items should be removed from prisoners are discussed and recorded at ACCT case reviews; • Carrying out ACCT observations at irregular intervals to prevent prisoners being able to predict when they will take place; • Completing the triggers section of the ACCT document 	Accepted	<p>The procedures of how staff manage prisoners at risk of suicide or self-harm in line with national guidelines have been reviewed by the Head of Safer Prisons. This review included a full review of PSI64/2011 in September 2014. All current procedures now comply with the standards set out in the PSI. This has been supported by the positive results of the safer prisons custody audit in August 2014, where the establishment was rated green with only one recommendation. The one recommendation related to written correspondence with the family of the deceased. Learning from this has been incorporated into the procedures to ensure that appropriate standards are maintained. All staff have been reminded of the process of managing prisoners at risk of suicide or self harm This was communicated to staff through team huddles and Full Staff notice on the 11th February 2015.</p> <p>All newly-recruited Prison Officers and operational support staff receive the "Introduction to Safer Custody" training, which covers the recommendations listed.</p> <p>In August 2014, the prison introduced a regular refresher programme to be delivered to staff on a regular basis to focus on the specific learning needs as identified by their manager.</p> <p>Multi-disciplinary case reviews involving all relevant people are held. Where such comprehensive reviews are not possible, for example for unplanned reviews that must take place in the evenings, an interim review is conducted involving the night manager and healthcare, and a further full case review is conducted the following day. The needs of individuals at risk of suicide and self-harm are considered at the</p>	<p>Completed</p> <p>Deputy Director and Head of Health Care</p>	

Action Plan: The man – HMP Peterborough on 28/8/14

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<p>complex needs multi-disciplinary meeting that takes place every Monday morning</p> <p>All staff are briefed at shift handovers about any prisoners on an Assessment in Care and Custody Teamwork (ACCT), and are made aware of significant health plans and medical information. ACCT documents are checked routinely by the Safer Prisons manager and weekly by a member of the management team.</p> <p>All available information, including historical information, about prisoners arriving at the establishment is considered by both healthcare and induction staff when determining the level of risk of self-harm.</p>		
2	<p>The Director and Head of Healthcare should make active efforts to ensure that all prison and healthcare staff are made aware of and understand their responsibilities during medical emergencies, including that staff:</p> <ul style="list-style-type: none"> • Carry anti-ligature cut down tools at all times when they are on duty; • Open cells as quickly as possible, using emergency keys at night, to administer basic life support; • Bring relevant emergency first aid equipment 	Accepted	<p>Anti-ligature cut-down tool All Officers, Senior Prison Custody Officers, and night staff have been issued with an Anti-ligature cut-down tool which is to be worn at all times which has been recognised as standard practise if on duty. These are issued individually as part of staff’s personal equipment.</p> <p>Refresher/Staff awareness for the use of anti-ligature tools is supported through the line managers or Safer Prisons Manager.</p> <p>Entering a cell A local recognised process has been implemented for when staff enter a cell on their own where there is, or appears to be, immediate danger to life. The process includes raising staff awareness for managing individuals that are at-risk and justifiable decisions on when to enter a cell where life is endangered. Staff were briefed of the new process on</p>	<p>Completed</p> <p>Deputy Director and Head of Health Care</p> <p>Completed</p>	

Action Plan: The man – HMP Peterborough on 28/8/14

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<p>immediately to a code blue; and</p> <ul style="list-style-type: none"> • Call an ambulance as soon as a code blue alarm is made. 		<p>28th August 2014</p> <p>Sealed Pouches All Officers, Senior Prison Custody Officers, and night staff are issued with a sealed pouch of keys on commencement of their night shift. This is attached to their key chain whilst on duty before leaving the gate lodge, and is attached prior to leaving the gate lodge. A reminder brief was issued on the 28th August 2014.</p> <p>Medical Emergency Response Codes: A Staff instruction will be re-issued in March 2015 identifying the critical elements of a medical response, including what first aid equipment to bring and immediate actions that should be taken and followed.</p>	<p>Completed</p> <p>Target date for completion: 13.03.2015</p>	