

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man  
at HMP Peterborough in August 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 investigation report into the death of a man, who was found hanging in his cell at HMP Peterborough on 10 August 2012. He was 61 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical review was conducted into the man's clinical care at the prison. HMP Peterborough cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man had been in custody since 21 February 2012 and did not settle easily into prison life. He was reclusive and rarely mixed with other prisoners. Prison staff began suicide and self-harm monitoring procedures on 8 July, after he said he had tried to hang himself during the night. He continued to attempt to tie ligatures around his neck. On 10 August, the man did not come out of his cell at breakfast time when he was unlocked just after 7.20am but another prisoner said he had seen him alive in his cell not long after. The officer who unlocked his cell in the morning did not check on him properly and later recorded an entry indicating he had seen him on the landing at 7.30am, when in fact he had not left his cell that morning. The man was found hanging just after 8.00am.

The investigation found that the man received some good staff support under suicide prevention procedures, but there was a lack of clarity among healthcare staff about how his mental healthcare was managed. There were several references to a referral to a psychiatrist but no one knew whether this had been done or whether it was even necessary. Staff observations and conversations agreed as part of suicide prevention procedures offered support the man, but were not enough on their own to help him come to terms with his feelings and circumstances.

The investigation identified a need to improve the management of mental healthcare for prisoners with high risk behaviours as well as some deficiencies in compliance with the suicide and self-harm monitoring guidance. It is a concern that the man's welfare was not checked on the morning of his death, both at unlock and as part of his required monitoring as a prisoner at risk of suicide and self-harm. While we cannot know whether this would have altered the outcome, prison staff need to understand the importance of such checks. I am aware that the Director of Peterborough has already taken action to reinforce this, as well as taking steps to further minimise ligature points in cells.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**July 2014**



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## SUMMARY

1. The man was sentenced to prison on 21 February 2012 and taken to HMP Chelmsford. Concerns had been raised about the man's state of mind and he began to be monitored under suicide and self-harm procedures as soon as he arrived at the prison. He had a history of anxiety and depression and had been prescribed medication by his community GP. Over the next few weeks, the man seemed to settle into prison life at Chelmsford and the monitoring stopped. A psychiatrist and a member of the mental health in-reach team saw the man while he was at Chelmsford and he continued to be prescribed medication for anxiety and depression.
2. On 6 June, the man transferred to the vulnerable prisoner unit at HMP Peterborough. Over the next few weeks, his anti-depressant medication was increased. On 5 July, one of the prison doctors recorded in the man's electronic medical record that the mental health in-reach team had seen him and was referring him to a psychiatrist. The in-reach team at Peterborough do not use the electronic medical record and there is no written note of their meeting with the man or of any referral to a psychiatrist in his records.
3. On 8 July, the man began to be monitored again under suicide and self-harm procedures after he had tried to hang himself during the night. He put ligatures around his neck on four further occasions and, as a preventative measure, he spent brief periods as an inpatient in the prison's healthcare centre. The man told staff that he did not want to die but felt worthless. He said that he expected staff to find him when he attempted to harm himself. At a case review on 5 August, the man seemed more upbeat than usual and told those at the meeting that he no longer had any suicidal thoughts.
4. On 10 August, the officer who unlocked the man for breakfast, at 7.20am, did not check on him when he opened his door. Another prisoner saw him in his cell at 7.36am. At 8.03am, a short time after breakfast the man was found hanging. Staff acted quickly but resuscitation efforts failed to revive the man and he was pronounced dead at 9.05am.
5. We found that some important elements of the suicide prevention process were not followed correctly. The frequency of required observations was not always clear and staff often failed to record them, only noting the meaningful conversations. Insufficient consideration was given to the possibility of the man sharing a cell. Some staff did not have a clear understanding of their responsibilities in the process.
6. Overall, we considered that the man's risks could have been managed more effectively. Many of his ligature attempts seem to have been in an effort to move to the healthcare centre but little was done to explore or manage this. The mental health in-reach team was not sufficiently proactive. There was no planned ongoing support and he did not see a psychiatrist. We have made recommendations about the mental healthcare services and the suicide and self-harm process.

## THE INVESTIGATION PROCESS

7. Notices were issued announcing the investigation to staff and prisoners and inviting anyone with relevant information to contact the investigator. No one came forward.
8. The investigator, visited HMP Peterborough, where she met the prison's liaison officer, as well as other members of the senior management team and collected the man's records. The investigator visited the wing where the man lived and the healthcare centre.
9. A clinical review was carried out into the man's clinical care in prison. The clinical reviewer and investigator jointly interviewed eight members of staff at Peterborough on 16 and 31 October 2012. The clinical review and an addendum are attached as annexes to this report.
10. Her Majesty's Coroner for Peterborough was informed of the investigation. A copy of the report has been sent to him. A post-mortem report confirmed that the man died from hanging.
11. One of the Ombudsman's family liaison officers, contacted the man's family to explain the investigation and invite them to identify issues for the investigation to take into account. The man's family asked that the investigation consider the following questions:
  - Had he been depressed and had he taken any drugs?
  - Was he actually alive and well when he was unlocked in the morning, taking into account that he was found hanging very shortly afterwards?
  - Were his actions a cry for help because he was unable to tell people how he was feeling?
  - Was he in a cell on his own?
  - Was he on medication such as anti-depressants?
12. I apologise for the delay in issuing this report, which was caused by staffing changes during the course of the investigation and a backlog of cases to be cleared.

## **HMP PETERBOROUGH**

13. HMP Peterborough opened in March 2005 and is privately run by Sodexo Justice Services (SJS). It houses male and female prisoners in separate areas. For male prisoners, it serves as a local prison that sends and receives prisoners directly to and from the courts. It holds up to 624 men.
14. The prison has 24-hour healthcare cover. Cambridge and Peterborough NHS Foundation Trust provides a seven-day mental health service. There are nine practitioners as well as a number of visiting psychologists and a visiting consultant psychiatrist. At the time of the man's death, the psychiatrist visited the prison one morning a week and typically saw three patients at each session.

## **HM Inspectorate of Prisons**

15. The Inspectorate of Prisons last conducted an announced inspection of the prison in April 2011. Inspectors found that most vulnerable prisoners felt safe on W2 unit and were positive about the support from officers who worked there. Their access to the general regime, including education, gym and the library was poorer than for other prisoners. Assessment, care in custody and teamwork (ACCT) documents were found to be generally of a high standard with good support from mental health nurses at reviews. Mental health services were assessed as good but there were no day care services for prisoners with mental health problems who found it difficult to cope on the wings. Emergency equipment was readily available and checked daily. All nurses had up to date training in basic life support.

## **Independent Monitoring Board**

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community, who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The most recent IMB report highlighted that a multidisciplinary forum met every three weeks to discuss the safer custody care of the most complex prisoners. They also noted the changes to the provision for those with complex mental health needs and considered that staff had developed a deeper understanding of the issues.

## **Previous deaths in custody at Peterborough**

17. There have been no other self-inflicted deaths at Peterborough in the past three years.

## **Assessment, Care in Custody and Teamwork (ACCT)**

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner

anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

## KEY EVENTS

19. The man appeared at South East Essex Magistrates' Court on 30 September 2011, charged with sexual offences. He pleaded guilty to all but one of the charges and was given bail. The man had a long history of anxiety and depression and had spent four weeks as an inpatient in a psychiatric health hospital before his arrest.
20. When the man reported to Basildon Crown Court for his trial on 21 February 2012, he told court staff that he had tried to hang himself two weeks earlier. They monitored him during the remainder of his time at court. He was sentenced to a total of six years imprisonment and taken to HMP Chelmsford. A person escort record (PER) accompanies prisoners on all journeys between prisons, police stations and courts and is a communication tool about a prisoner's risks. The man's PER alerted prison staff that he had attempted suicide by "self-strangulation" a few weeks before. A court officer had also completed a suicide and self-harm warning form which was handed over to prison staff at Chelmsford.
21. Reception staff at Chelmsford began monitoring the man under Assessment, Care in Custody and Teamwork (ACCT) procedures (the Prison Service process for supporting prisoners at risk of suicide and self-harm). The nurse in reception recorded on the SystmOne electronic medical records that the man had not been in prison before, appeared low in mood, expressed feelings of disappointment in himself because of his offence and had tried to strangle himself a few weeks earlier. His community GP confirmed that the man had a history of anxiety and depression for which he had been prescribed citalopram (for mild to moderate depression) and zopiclone (for insomnia).
22. At the man's ACCT assessment meeting the next morning, an officer asked him what was causing his distress and wrote:

"[the man] is very upset and scared about being in prison for the first time and doesn't think he will be able to cope. He also feels very alone, he has lost his family and friends due to a sexual offence... and is feeling very alone, lost and guilty".
23. The officer listed the next steps to take, including a referral to a doctor about the man's depression and problems sleeping and allocating him to D wing (the vulnerable prisoner unit). The GP saw the man a short time later and continued his prescription of citalopram and zopiclone. The mental health team recorded that they had referred the man to see the psychiatrist and he moved to D wing that afternoon.
24. Over the next few days, the man began to settle. At an ACCT case review on 28 February, he said he felt supported by staff and prisoners and safe on the wing. The ACCT was closed (and a post-closure review was held a week later). The next day, the man met his offender supervisor. They discussed a forthcoming sentence planning meeting and how the man was finding the experience of being in custody. The man said he had lived an isolated life in

the community and had continued this in prison. She advised him to try and integrate himself and start talking to other prisoners.

25. The sentence planning meeting took place on 12 March, with the offender supervisor and the man's offender manager. On the same day, the man was assessed by the psychiatrist who noted that zopiclone helped him to sleep but that he did not feel any benefit from the citalopram as he was still upset about his offences. The man presented as relaxed and, although there had been instances of self-harm, he denied any active plans. The psychiatrist diagnosed "Depressive symptoms related to current life situation". The man's citalopram and zopiclone were stopped and replaced by another anti-depressant, mirtazapine, (prescribed for severe depression) to be taken at night. A review was planned for four weeks later.
26. The consultant psychiatrist noted, the psychiatrist's findings in a consultation with the man on 16 March. The man said he did not have thoughts of suicide or self-harm but that he was not sleeping well (in part this was thought to be due to the fact that his cell mate was rather nocturnal). The consultant psychiatrist thought the man's presentation was "understandable in the context of his current situation". She also noted that this was his first time in prison. She increased the mirtazapine to 30mg after one week (typical doses are between 15 and 45mg per day) and referred him to Atrium (a psychological support group in the prison) to help with his feelings of anxiety around others.
27. The man was assessed for one-to-one counselling sessions on 4 April and placed on the waiting list. At a mental health support meeting on 7 April, a registered mental nurse (RMN) noted that the man was constantly going over his offence and the consequences. He felt socially isolated as friends and family had all turned their backs on him, but he was able to concentrate on reading books or watching the television for short periods of time. He recognised that these activities, as well as his work in the laundry, acted as distractions. The man told the RMN that he was keen to start his counselling with Atrium as he wanted to be more settled in himself. She felt he showed motivation to address his problems.
28. During a meeting with the man's offender supervisor on 13 April, the man became very upset. The Offender supervisor and an officer therefore opened an ACCT plan and staff observed the man every hour. At the first case review at 10.10am the next morning, the man said he had no thoughts of suicide or self-harm. He explained that he had felt low because he had learnt he was losing his flat and about life in general, but that he was "too selfish to harm himself". He was able to discuss ways to improve his current situation such as applying for a prison visitor, attending work and mixing with his peer group. The case review manager felt the man was positive in mood and body language and closed the ACCT. A post-closure review was held a week later.
29. On 3 May, the mental health nurse noted that after four weeks the man was not feeling any benefit from the higher dose of mirtazapine. She encouraged him to talk to Listeners (prisoners trained by the Samaritans to provide confidential support to other prisoners in distress), staff or someone from the

chaplaincy if he was feeling low. The man said that he did not discuss his feelings with strangers. The mental health nurse explained to the man that anti-depressant treatment takes about one month to start to take effect but that it would not completely resolve his low mood caused by his imprisonment. He denied any suicidal thoughts and, although he was a little low in mood, he appeared to be keeping himself motivated. The mental health nurse decided that he should continue to receive support from nurses.

30. On 6 June, because of population pressures on places at Chelmsford, the man transferred to HMP Peterborough. The Person Escort Record which accompanied him referred to the two periods of ACCT monitoring, that he was suffering from depression and his attempt to hang himself on 21 February. A separate envelope contained further information about the man's mental health. A healthcare assistant saw the man when he arrived at Peterborough and referred him to a prison GP, who continued the prescription of mirtazapine.
31. The man was allocated to W2, the vulnerable prisoner unit at Peterborough and a personal officer was assigned to him. (Each prisoner has a nominated personal officer whose job it is to get to know him and act as a point of contact for help.) On 7 June, during his first meeting with his personal officer the only issue that the man raised was that he had been on the enhanced (highest) level of privileges at Chelmsford and wanted that to continue at Peterborough. The officer told him that this had already been confirmed. On 15 June, the man asked the officer about the possibility of getting a job on the wing so that he could spend more time out of his cell. The officer explained the process for applying for a job.
32. On 20 June, a prison doctor increased the man's dose of mirtazapine to 45mg, as he had not been eating or sleeping well, felt low and continued to isolate himself. The doctor diagnosed anxiety with depression and advised the man to make a personal effort to help improve his mood. On 20 June, the man spoke to the officer again about a job. The officer told him that he had spoken to the staff responsible for allocating work and he was now on the waiting list.
33. Two days later, on 22 June, the doctor saw the man after wing staff had expressed concern about his level of depression. The man had said he felt he "was losing it". The doctor referred him to the mental health in-reach team but thought it was too soon to judge whether the increased dose of mirtazapine was effective and set a review date for two weeks later. In the meantime, he prescribed the man sleeping tablets for a few days.
34. On 30 June, The officer contacted healthcare staff after the man said he had mental health problems and could not cope with being in prison. Two days later, on 2 July, wing officers spoke to healthcare staff again and told them that the man was not coming out of his cell and was hitting his head. That evening, the man told a locum GP that he could not stop thinking, had recurrent thoughts about his offence and felt guilty all the time. The GP noted the man said he would like to sleep all the time to switch off his mind and considered that he was clearly asking for help. Her view was that his risk of

deliberate self-harm was very low. She prescribed quetiapine (25mg), (an anti-psychotic medication that can be used in the treatment of major depressive illness and decrease agitation) and referred him for an appointment with the prison mental health in-reach team.

35. On 5 July, the man told the doctor that although the quetiapine was not working, he wanted to keep taking it. The doctor noted that someone from the in-reach team had seen the man that day and was referring him to the psychiatrist. There is no record of this consultation with the mental health in-reach team, apart from the original appointment letter. The first written entry in the man's medical record about the mental health team seeing the man was on 14 July, when a mental health nurse, attended an ACCT review meeting. The man asked to see a psychiatrist that day but was told it was not possible. The same day, a nurse noted that the man was waiting for an appointment with a psychiatrist.

### **Suicide and self-harm monitoring from 8 July**

36. An officer started ACCT monitoring at 9.00am on 8 July, after the man told him he had tried to hang himself during the night. The man said he was "going mad" and that he was worried about his mental health. The officer completed the Immediate Action Plan section of the document (which should have been completed by a unit manager). The plan was to observe the man hourly, keep him in a single cell and offer access to Listeners and the Samaritans phone. The officer noted that healthcare staff had referred him to see the GP and that he had been seen by the mental health team before. A doctor saw the man an hour later, at 10.00am, and admitted him to the healthcare inpatient unit.
37. Another officer, conducted an ACCT assessment interview, and noted that the man had lived in isolation before coming to prison and had found it hard to mix with other prisoners. The man told the officer that he had tried to hang himself the night before and he wanted to die. He felt very scared and anxious. When asked about suicidal intentions, the man told the officer he would like to be dead and that if there were a tablet he could take to do this, he would. He added that he would not hurt himself that night. He felt his current medication was not helping him and he could not sleep properly. He described how he had lost everything because of his offence and felt he had no reason to live. The officer noted the following about next steps:

"Speak to in-reach, appointment has been made. Mental health issues. Medication to help him sleep."
38. The man remained in the inpatient unit overnight, subject to hourly observations. (A subsequent check by the suicide prevention co-ordinator highlighted that these checks were not meant to be regular and predictable.) He told a nurse the next day that, although he had appeared to be asleep during the night, in fact he had been awake.
39. The man's first case review was at 11.00am on 9 July with his case manager and officer from the healthcare centre. The case manager described him as,

“a very quiet chap, very withdrawn, dishevelled, unkempt looking”. The man said he did not like noise and that he had lived for the past year as a recluse. He described feeling scared when there was a knock on his door. In her summary of the meeting, the case manager said wing staff felt there were “no thoughts of suicide and self-harm” because the man said he could not physically hurt himself. The man was happy to return to the wing but wanted a quieter cell. They assessed the risk of harm to himself and the likelihood of future risk behaviours as both low.

40. The caremap lists the issues and action required to support a prisoner at risk. The first issue listed was sleeping and anxiety for which he was to see the GP and an appointment was booked for 11 July. The second was mental health concerns for which a mental health alert form was to be completed. The third issue was to get financial help about which a referral had been made. The fourth issue was general suicide and self-harm support. The man was told about the Listeners, the Samaritans phone, safer custody packs, a journal and the chaplaincy team. It was noted that all but the Listeners service was declined but the man subsequently accepted offers of a safer custody pack from time to time. (Peterborough use safer custody packs to try and distract people from self-harm. Items include cards, crosswords and art and craft activities.) The man returned to W2 at 2.20pm that afternoon. The ACCT observations continued at one an hour and three recorded conversations with staff each day.
41. On 11 July, the man told the officer that his head was still a bit “messed up”. The GP saw the man, who complained of poor concentration and being unable to relax. He said he did not think that the quetiapine was helping. The GP increased the dose to 50mg, while waiting for psychiatric input.
42. On 13 July, the man told the officer he had been sleeping better, but a few hours later told him he had tried to harm himself the previous evening. His second case review meeting was held at 11.30am, chaired by the case manager and also attended by two senior officers. The summary noted that the man continued to be affected by noise on the wing, so they would try to get some ear plugs. Some of the other issues had already been actioned. The man said he had thoughts of self-harm but could not do anything to physically harm himself. It was decided to continue ACCT monitoring until the mental health in-reach team had seen the man. The observations remained the same at hourly intervals, with staff to have three meaningful conversations with him each a day. The next case review was scheduled for 20 July.
43. On 14 July, another prisoner told an officer that the man had swallowed objects and tried to hang himself during the night. The officer noticed marks on the man’s neck and that he was visibly distressed. He asked for a nurse to attend and increased the observations to two an hour.
44. A nurse attended an ACCT review held that day because of the man’s self-harm. The man said he did not want to commit suicide but felt worthless due to the thoughts and feelings going on in his head. He explained he had used a sheet and clothes to make a ligature but had had second thoughts about going

through with it. He agreed that he must have a desire to carry on living but said he “hates it when the day starts and always wants it to end”. He was unable to concentrate on the television or read and said he wanted to see the psychiatrist that day or be prescribed some strong medication.

45. The nurse and the case manager decided it would not be of benefit for the man to move to the inpatient unit. The caremap listed four issues, including the need for a mental health assessment and a review by a psychiatrist. (the nurse noted the plan was to liaise about the appointment with the psychiatrist and any future intervention needed.) The monitoring level was set at two observations each hour and three conversations with staff each day. (This was not recorded on the front of the ACCT document as it should have been, but was written in the on-going record). The man moved cell later that day as his cell was near the pool table and he did not like the noise.
46. The man told the officer during the morning of 16 July, that he could not cope and needed to see a psychiatrist. He also told another prisoner that he had swallowed a key. In the afternoon, he told the GP that he had swallowed the key because he wanted to choke himself but now saw it as “silly”. The GP noted that the man felt tense and anxious and decided to review him in a week.
47. Wing staff continued to monitor and support the man over the next few days. He stayed mainly in his cell, watching television, but talked to staff when they went to see him. At a case review on 20 July, he said that he had no thoughts of self-harm and his observations were reduced to one each hour. (The next scheduled review was 24 July, after his appointment with the in-reach team.) The man played in a pool tournament on 21 July and later said that it had helped take his mind off things.
48. On 23 July, the man had an appointment with a member of the mental health in-reach team, but he refused to go and the officers could not persuade him. The member of staff from the mental health in reach team saw him at an ACCT case review the next day, when she noted he was unkempt, had racing thoughts and thoughts of suicide and self-harm. The wing staff told her that the man did not usually come out of his cell during association periods. The member of staff from the mental health in reach team decided to do a full assessment at the weekend (28/29 July) and the next ACCT review was scheduled for 30 July.
49. On the morning of 26 July, the man told the officer that he felt a lot better than he had recently. However, at around 2.35pm, the officer checked the man’s cell and saw him making a ligature in the toilet area of the cell. When the officer told him to take it off his neck he said that the “whirring in his head was unbearable” and that he wanted it to end. The officer called a nurse. An interim ACCT case review was held and the nurse made an appointment for the doctor and a referral to the in-reach team. The man calmed down and his observations were increased to two each hour – again this was not written on the front of the ACCT document.

50. The next day, 27 July, the staff member from the mental health in reach team assessed the man at 10.00am. He was described as asking for help but thinking constantly of ways to commit suicide. He felt he had lost everything and lacked motivation to do anything, even washing, cleaning or eating. Communication with others scared him and he found it difficult. The man said he had been depressed for about 18 months. His perception was that no one was helping him. The member of staff from the mental health in reach team explained to him that the assessment she was making was in response to the referral from the GP on 26 June. She later said that he had it “firmly stuck in his mind” that seeing the mental health services was going to make him well immediately. The man said he saw suicide as the only way for this all to end but that he was a coward and could not think of a method in prison that would be painless. He felt anxious all the time and repeated that he found the noise on the wing very difficult.
51. The GP also saw the man on 27 July and increased his quetiapine to 50mg twice a day (the most common side effect of quetiapine is a strong desire for sleep/a state of near sleep). A review date was set for two weeks later. An ACCT management check was done by the ACCT coordinator in the safer custody team on 27 July, who said the case review should consider closing the ACCT because there had been no self-harm. This was not correct as the man had been found with a ligature just the day before. The man played pool later that day and talked to other prisoners, which staff noted as positive, but out of character.
52. On 29 July, the officer thought the man appeared to be in a much worse condition than usual and described him as shaking badly and looking “very wild-eyed”. The member of staff from the mental health in reach team agreed to see him and a Senior Officer was informed. Events during the rest of the day are unclear from the ACCT document and there were no entries recorded between 9.10am and 12.10pm, although the man was meant to be observed two times an hour. However, other records give a fuller picture.
53. The man’s SystmOne medical record shows that a Sister saw him in his cell in response to an alert at 9.10am, due to an attempted ligature. He was restless and pleading for help, so he was admitted to the healthcare centre. His wing history file records that he was admitted into healthcare (cell 5) because he had attempted to tie a ligature and was waiting for a review about his mental state.
54. An ACCT case review was held at 12.00pm with several staff present, including the member of staff from the mental health in reach team and Sister. It was noted in the summary of the case review that the member of staff from the mental health in reach team’s review indicated that the man had mental health issues and that she had referred him to see a psychiatrist “as soon as possible”. (The member of staff from the mental health in reach team recorded in the medical record that he had been admitted to healthcare with a view to seeing a psychiatrist as soon as possible.) The man was very confused, incoherent and continually said, “I’ve gone mad in my head, my head. I should die”. His observations were increased to three each hour. The

level of required observations was not noted on the front cover of the ACCT book or in the on-going record. Nevertheless, staff carried out the observations and recorded them in the ACCT book. The ACCT on-going record made no reference to him tying a ligature that morning, his move to the healthcare centre or the case review. There are entries in the on-going record by the officer from 12.10pm onwards which relate to the man's time in the inpatient unit. The member of staff from the mental health in reach team's entry at 3.24pm also indicated that the man had ligatured quite badly (so that it had to be cut off) and that a nurse had admitted him into the healthcare centre with a view to him seeing the psychiatrist as soon as possible. The member of staff from the mental health in reach team considered that the man's anxiety levels were high. He remained in the healthcare centre overnight.

55. An ACCT case review was chaired by a Senior Officer (SO) and attended by the member of staff from the mental health in reach team on 30 July. Although he had tied a ligature the day before, they considered that the risk of self-harm was now low but noted that the man "still has issues with the noise in his head". The man told the meeting he did not want to kill himself but that he sometimes got to the end of his tether. The man was told he would have a follow up appointment with the mental health in-reach team to look at how they might help him. The member of staff from the mental health in reach team wrote in SystmOne that the man "would be further assessed by my colleague tomorrow". The man returned to W2 wing, having apparently "settled". Although the review had considered him low risk, he was still required to be observed three times an hour. The officer wrote that healthcare had discharged him with "no issues". The PCO talked to the man on 31 July and said he seemed the calmest he had been for a while.
56. In the early morning of 2 August, the man put another ligature around his neck. The Sister went to see him at about 7.00am. She described the man as very agitated, pacing his cell and repeating, "I'm going mad, I'm going mad". She took him to the healthcare centre to be assessed by the GP. The Sister said that the doctor saw all prisoners in the inpatient unit on their routine daily ward rounds, but there is no entry in either the man's SystmOne or ACCT record to indicate that he was seen by a GP.
57. Another member of staff from the in-reach team, attended an ACCT case review in the inpatient unit at 10.00am that morning, along with a Sister and Officer. The man said that when he tied the ligature he had not wanted to kill himself and knew he would be found. Another member of staff from the in - reach team advised him to keep himself occupied and establish a routine, as well as continuing his medication. A new caremap was written listing three issues. The first concerned the man's mental health problems. The member of staff from the in - reach team wrote that he had assessed the man and no follow up was required. The second was for the man to be encouraged to get a routine going and that wing staff were to help this by encouraging him to get up, shower and do some work. The third issue was something to distract the man from self-harm for which wing staff were to give him self-harm support packs to help keep him occupied.

58. Another member of staff from the in - reach team later wrote to a doctor to say that the two mental health staff who had seen the man previously were “somewhat apprehensive about the risks he posed to himself through his behaviours”. The man said he found it difficult to cope in prison, was in constant fear on the wing and did not think he would be able to concentrate on work or education. He had no desire or motivation to engage and felt that he needed medication to help this. His sleep was disturbed at times because of his restless thoughts and regular observations by staff. When they discussed his recent suicide attempts, the man said he had no intention of ending his life and that he had tied ligatures at a time when he knew officers would find him. They spoke about the risks of him doing this and of misjudging when the officers did their checks. The man said he wanted to be relocated to the healthcare centre as he did not want to be on the wing.
59. In his letter to the doctor, the member of staff from the in - reach team added that although the man described himself as very depressed, objectively this did not appear to be the case. He felt that, based on the man’s lack of acute depressive symptoms and suicidal intent, his risk of suicide was, at that time, low. It was difficult to predict his future risk because of his “impulsivity and maladaptive ways” of seeking alternatives to his current location on the wing. The man had asked if he could go to the separation and care unit as an alternative to the wing. He had tentatively agreed to explore some in-cell work options in order to start the structure of a daily routine. The member of staff from the in - reach team concluded that the mental health in-reach team were not going to add the man to their caseload but that they would continue to work with the doctor and the prison staff in an advisory role.
60. The officer was not happy about the man returning to the houseblock that day as he did not feel the man was coping very well with being in prison. He spoke to the officer about the situation, who told him the mental health in-reach team did not think the man needed to be an inpatient in the healthcare centre. The man’s personal officer said the man seemed to have a more positive attitude initially and talked about the support available to him.
61. ACCT monitoring continued, but the level of observations was unclear. Both three per hour and two per hour were written on the front page of the ACCT for 2 August and the case review note does not record the agreed level.
62. On 3 August, the man told an officer that he still felt “mad” and was never going to get to see a psychiatrist. The officer advised him to make a complaint if he felt the in-reach team or other departments were taking too long to see him. The next day, the man asked the officer if he could put his name down for the weekend pool competition and then came out of his cell to take part.
63. The Senior Officer said the man did not like anybody coming near him and was very much a loner. He was very surprised when staff told him that the man had come out of his cell and played pool at the weekend. The SO described how the man would talk to staff on some days but on others only gave yes or no answers when they tried to engage him in conversations. He often talked about noises in his head. He did not have any visits or make any

phone calls during his time at Peterborough. The SO added that, whenever they talked to the man about having a job or taking education classes, he flatly refused.

64. At the ACCT case review on Sunday 5 August with the Senior Officer, an Officer and a nurse, the man said he was coping better, had been socialising with other prisoners and no longer had suicidal thoughts. The review noted that the man had been out playing pool on the wing and that he was trying to mix with others. The officer said that the man definitely seemed better at this review, he was more upbeat and even told a few jokes. The man said he was coming to terms with being in prison and the length of his sentence. He spoke much more at this review than he had previously. His ACCT observations were reduced to one an hour and he later told the officer that this would enable him to get more sleep.
65. The next day, the man spent most of the morning watching the Olympics on television. In the afternoon, an officer spoke to him about how his day had gone and the man maintained good eye contact but did not seem particularly talkative. On 7 August, the man slept during the day and watched television in the afternoon. He talked to some other prisoners as he was on his way to the servery to collect his meal. The officer noted that he seemed in good spirits on 8 August. It was the man's birthday but there was no reference to the staff being aware of this.
66. On 9 August, the man told the officer that he had been watching a lot of the Olympics on television. When another officer spoke to him in the afternoon, he recorded that he seemed to be in good spirits and had been doing Sudoku puzzles. The man had said he was still fighting the urges but was going strong. Later that day, the man told another officer that he was "not good" and that he could not settle on the wing or get any sleep.
67. An auxiliary officer was responsible for patrolling W2 during the night of 9 August. This included checking the four prisoners on ACCT monitoring, one of whom was the man. At the time of her first check (8.00pm), she noted in the ACCT book that he was asleep in his bed. The auxiliary officer carried out hourly checks on the man throughout the night (CCTV footage confirms that these checks were done). He remained asleep all night. Although he was supposed to have been checked hourly, no formal ACCT checks were carried out after the last one by the auxiliary officer which was sometime between 6.00am and 6.10am (the timing of the entry in the record is unclear).

### **Events of 10 August 2012**

68. An officer was the early patrol officer who took over from the auxiliary officer on 10 August 2012. He arrived at houseblock 4 at 6.20am and received a verbal handover about the prisoners who were subject to ACCT monitoring and support. During the morning roll count of all prisoners, the officer went to the man's cell at 6.33am and saw him sitting on his bed. He did not speak to

him as it was just an observational check and made no entry in the ACCT record, which would not normally be required for such a check.

69. The man's personal officer was in houseblock 4 at around 6.40am and was due to start a morning shift on W2 with another officer at 7.00am. He went onto the wing at around 7.15am and the two staff unlocked the servery workers so they could get ready to serve breakfast to the rest of the prisoners on the wing. At about 7.20am, the officers started to unlock the remaining men. The officer said he followed other officers' methods of unlocking cell doors (he had been in the job for about six months). He unlocked the man's door but to allow him privacy did not swing the door wide open. CCTV footage shows that he unlocked the man's cell at 7.21am. The officer said he saw part of the man's leg through the gap in the hinges of the door and that he was sitting on the bed. The officer said that he said "Good morning" but the man did not respond. Once the cells were unlocked, the officer went to the office to complete some administrative tasks. While doing this, he said he believed he had seen the man at the top of the landing at 7.30am. The man's ACCT book was open so he made an entry "The man came down to the lower landing this morning but went back to cell". In fact, CCTV footage shows that the man did not leave his cell at any time that morning.
70. A prisoner on the same wing as the man first met the man when they were at Chelmsford together. He told the investigator that the man had seemed all right at Chelmsford and had mixed with other prisoners more than he did at Peterborough. He said that the man had spoken to him about "strangling himself" and felt he had nothing to live for because his family and friends did not want to talk to him anymore. He did not get any money sent in and did not have a prison job, so struggled to afford tobacco. On the morning that the man died, the other prisoner said that on his way to breakfast he had opened the man's cell door flap and told him not to forget to come down for breakfast. He said the man seemed okay at the time. CCTV footage shows the prisoner looking into the cell at 7.36am. The prisoner continued on his way to collect his own breakfast.
71. After breakfast, the two officers were locking prisoners back in their cells, the prisoner said he had asked one officer to tell the man to clean his cell as he thought it smelt. The officer got to the man's cell at 8.03am. He could not remember whether the privacy lock was on (prisoners can lock their cell from the inside for privacy, but officers are able to unlock the door at any time). He opened the cell door and saw the man hanging between the toilet and the secure cabinet unit. He took out his anti-ligature knife and called to the other officer, who walked over (he estimated he was there within 40 seconds) and held the man up, while the officer cut two ligatures from around the man's neck.
72. The officer said the man made a gurgling sound and the officers thought he was breathing. His face was blue. They laid him on his bed and the officer felt for any air coming out of his mouth. There was none, so the officer started chest compressions. The other officer twice radioed for a medical response as the first message had not been heard. The officer said that as he was

giving the initial chest compressions he could hear air circulating as he pushed down. The noise of the air decreased as he continued with the compressions, but the officer thought some colour had returned to the man's face. There was no other sign that he responded at any time.

73. Another Officer and Senior Officer arrived at the wing about a minute later. The Senior Officer radioed for an ambulance to be called (the emergency services were called at 8.08am). The other prisoners on the wing were locked up. An operational manager, got to the cell about a minute later. An operational manager took over the chest compressions while nurses set up an oxygen cylinder and airway tube.
74. A nurse had taken the emergency grab bag with her, which contains basic equipment such as oxygen masks, Guedal airways and a blood pressure monitor. When she arrived, another nurse was already there with an oxygen cylinder and was giving this via a face mask. The nurse asked for the large emergency bag to be brought and a defibrillator (a machine which administers shocks to help restart a heart rhythm when this is possible.) This emergency equipment was stored in a central hub, just a few seconds outside each wing. The nurse put in a Guedal airway and transferred the oxygen to this. The nurse attached a saturation probe but she said that although the man was still warm, he was quite cyanosed and she did not expect to get any reading. (Cyanosed means a blue tinge to the skin – it is most noticeable on the extremities such as the lips, tip of nose and fingers.) There was no oxygen reading and no pulse. The nurse put on defibrillator pads but the machine advised not to shock because the man's heart had no shockable rhythm.
75. The duty manager and other managers went to W2 and the officer briefed them about what had happened. Paramedics arrived at the prison at 8.12am and used their own equipment to continue resuscitation efforts, starting at 8.17am. They moved the man to the floor of the cell, administered four doses of adrenalin and continued resuscitation attempts until 8.48am. There was no cardiac rhythm or respiratory effort at any time during their resuscitation attempts. The man was pronounced dead by the doctor at 9.05am.
76. A note was found in the man's cell after his death. Although not dated or addressed to anyone in, he had recorded some of his feelings:

“The day arrive when can't do anything about what going to happen. For days I being fighting my mind, I wish someone to be me for a while. My mind keeps thinking stupid things... I can't wait for the day to end. Can't concentrate on everything, I have gone mad in my mind...”

### **Liaison with the man's family**

77. The prison chaplain and another member of staff went to visit the man's ex-wife in order to break the news of his death - a journey of two to three hours. They arrived at 3.30pm, told her what had happened and offered their condolences. At her request, they also broke the news to his adult children.

78. The family liaison officer kept in contact with the man's ex-wife over the next few months. He explained that the prison would help with the cost of the funeral, outlined the role of the Coroner and offered a visit to the prison. With the agreement of his family, the family liaison officer and a Senior Officer attended the man's funeral service on 10 September.
79. During a visit to the man's ex-wife some months later, the family liaison officer explained that an internal investigation had taken place and that an officer had been dismissed as a result of the findings. His ex-wife said the man might have taken his life when he did because it was around the time of his birthday and it would have been their 40<sup>th</sup> wedding anniversary, had they still been married.

### **Support for prisoners**

80. Other prisoners subject to suicide prevention procedures were reviewed and monitored immediately. Case reviews were held the next day to discuss how they were feeling in case they had been adversely affected by the man's death. The Director issued a notice to prisoners, informing them of the man's death. He expressed condolences and advised how prisoners who felt affected by the news could seek help from wing staff and Listeners, the prison chaplaincy and the Samaritans.
81. A few days later, the Director instructed that the in-cell secure cabinets (in which prisoners stored prescribed medication) be detached from the walls of cells because the man had used this as a ligature point. They are now freestanding in the cells.

### **Support for staff**

82. A hot debrief took place at 9.30am, led by the Director. All the staff, healthcare and officers, who had been involved that morning attended the debrief.
83. A member of the care team (specially trained staff to support other staff at difficult times) got in touch with those staff who had been involved. Staff were offered ongoing support if they needed it.

## ISSUES

### Clinical review

84. The clinical review looked at the treatment the man received at Chelmsford and Peterborough and considered whether it was appropriate and equivalent to the care available in the community. After the initial review, he conducted further interviews and provided an addendum to his original report. Overall, he judged that the care was equivalent. However, he made a number of recommendations for improvement and those most relevant to the circumstances of the man's death are repeated in this report.

### *The man's mental healthcare*

85. The clinical reviewer said that, at Chelmsford, the man's low mood and depression were quickly assessed during the health screen in reception and his ongoing treatment set up. He was referred to the mental health in-reach service and was assessed by both a mental health nurse and a psychiatrist soon after arrival.
86. In NHS general practice, a patient's medical records are passed from one GP to another. In the case of a prisoner, an abbreviated record is sent to the prison. The letter from the man's GP gave little information about the depth of his isolation and poor mental health before he went to prison and none about his threats of suicide and the care and treatment he had received in a mental hospital. The clinical reviewer considered there would have been a better handover of information in NHS General Practice.
87. After his transfer to Peterborough, the man waited three weeks to be referred to the mental health in-reach team. No formal assessment tool was used at any time during his care at Peterborough. The use of such tools is standard practice in primary care, to specifically assess change in mood and response to treatment (but not as a tool to diagnose depression). The clinical review concluded that there was almost no communication between the mental health teams at Chelmsford and Peterborough. There was no clear and specific handover in the man's case when there were quite obvious problems. The man had been referred for counselling at Chelmsford and said to be looking forward to this, but there is no record this was considered at Peterborough. A faster or more complete handover might have facilitated the earlier input of the Peterborough in-reach team. We make the following recommendations:

**The Director and Healthcare Manager should ensure that the mental health in-reach team requests and obtains a comprehensive handover when a prisoner with known complex mental health problems transfers to Peterborough.**

**The Director and Healthcare Manager should implement standard depression screening and assessment questionnaires for prisoners**

**diagnosed with depression, at the initial medical assessment and during consultations, which should be used to assess and record levels of depression and responses to treatment.**

88. The man was seen by three members of the in-reach team on 14 July at an ACCT review, the member of staff from the mental health in reach team on 27 July for an assessment meeting and again on 29 July after putting a ligature around his neck. In addition, another member of staff from the in - reach team saw the man as part of an ACCT review on 2 August and subsequently wrote to the doctor. Another member of the mental health in-reach team, said the general feeling was that the man had not been adjusting to prison very well. He did not want to be on W2, but needed to be in that protected environment. When he moved to the healthcare centre, his presentation changed.
89. The member of staff explained that as the man was being treated by the GP, the in-reach team considered that they needed to wait and see what developed and if they needed to become more involved. The man had recently had an increase in medication and they thought they should wait until the GP reviewed it before deciding how to proceed. They believed that the man wanted them to fix things immediately with medication.
90. The member of staff described how prisoners are referred to see a psychiatrist and said it is a very individual process. Some people are seen by an in-reach worker and then a psychiatrist just a few days later. If the GP was in the process of treating a prisoner, the in-reach team might wait to see if this was necessary. There are several references to the man waiting for the input of a psychiatrist in both the SystmOne record and the ACCT case reviews. Some of the GP entries, for example, those by a doctor on 5 July and another doctor on 11 July, clearly indicate that they thought the man was going to be seen by the psychiatrist. It was not until the letter from Another member of staff from the in - reach team to the doctor on 2 August, that it was indicated that the man was to remain under the care of the GP and not the in-reach team and would therefore not be referred to a psychiatrist.
91. The caremap written after the ACCT review meeting on 14 July listed four issues. Two related to the man's mental health – to have a mental health assessment and see a psychiatrist. The ACCT case review on 29 July at which the member of staff from the mental health in reach team from the in-reach team was present said:

“... has completed a review and preliminary results show mental health issues. X has made a referral for him to see the consultant psychiatrist as soon as possible”.

This note indicates that those at the ACCT meeting thought the man was going to be seen by a psychiatrist and in fact that an urgent psychiatric referral had already been made. However, no referral to a psychiatrist was made at any time during the man's stay in Peterborough.

92. The clinical reviewer interviewed the three members of the mental health in-reach team who had assessed the man. He subsequently wrote an addendum to his clinical review, annexed to this report. The member of staff said the man felt depressed but on full clinical assessment showed no biological features of clinical depression. The man wanted to see a psychiatrist and the member of staff explained that the next stage would be to discuss the case at a mental health in-reach team meeting. At the assessment on 2 August, the man said he still felt depressed but another member of staff from the in - reach team thought he presented no evidence of clinical depression or psychosis. He was aware that his ligaturing behaviour was high risk but had no intention of ending his life and knew the wing staff would find him. Another member of staff from the in - reach team subsequently wrote to the doctor to say that the in-reach team were not taking the man onto their caseload.
93. The clinical reviewer said that the three assessments:
- “did not reveal evidence of clinical depression of a degree severe enough to warrant referral to a psychiatrist, but this was considered by the individual assessors and discussed by the mental health in-reach team meeting.”
94. The clinical reviewer noted that the process of referral to a psychiatrist is entirely within the in-reach team’s remit and part of their working process is to assess patients, discuss them within the team and with the GPs. Referral to a psychiatrist occurs where the team believes this to be appropriate. After an assessment on 29 July, it was noted that the member of staff from the mental health in reach team had referred the man to a psychiatrist, but there is no record of the referral and it does not seem to have taken place.
95. The availability of psychiatrists in the prison during June, July and August was low because of sickness (less than a third of the normal level of sessions). The in-reach team and Cambridgeshire and Peterborough Foundation Trust stated that a psychiatrist was always available for urgent discussions and advice and that the availability of a psychiatrist was not a factor in the decision not to refer the man.
96. The clinical reviewer also sought the opinion of an independent consultant psychiatrist, who, on the clinical information available, felt quite strongly that the man ought to have been reviewed by a psychiatrist due to his recurrent use of ligatures. However, the clinical reviewer believed that a large part of the reasoning for this was based on providing protection for the in-reach team. His view was that even if a psychiatrist review had taken place, “it was by no means likely to stop the risk taking behaviour and therefore was not likely to have altered the final outcome of the case”.
97. We cannot speculate on the outcome or what measures or support might have been put in place had the man seen a psychiatrist. We therefore focus on whether it was unreasonable that a referral was not made. The clinical reviewer concludes that the assessments of the mental health in-reach team

were backed by clinical judgement and they considered that he did not need a consultant psychiatric assessment and was satisfied that the man's healthcare was equivalent to that he could have expected in the community. However, he acknowledges that best practice would have been to refer him to or discuss his case with a psychiatrist. The member of staff from the mental health in reach team from the mental health seems to have considered a one stage that a psychiatric referral was warranted but no action was taken.

98. There remains considerable confusion as to whether a referral to a psychiatrist had been made or intended but we consider it would have been better if the man had been referred to see a psychiatrist. We base this opinion on the view of the independent consultant psychiatrist who contributed to the clinical reviewer's review; the fact that the man had been prescribed two medications (mirtazapine and quetiapine) both used to treat major depressive disorder, without psychiatric input; his recurrent attempts to ligature, the fact that he showed no real sustained improvement in his mood during the ACCT process and that it was stated at his ACCT review on 29 July that the member of staff from the mental health in reach team from the mental health in-reach team had assessed him and referred him to see a psychiatrist as soon as possible.

**The Healthcare manager should ensure that there is effective and clear liaison between the primary care providers and the mental health in-reach teams which prioritises urgent referrals to a psychiatrist for prisoners with high risk behaviour.**

#### *Emergency response*

99. At the time of the man's death, Peterborough did not use a code system to alert medical staff to the nature of emergency incidents. A nurse said she did not know the nature of the emergency until she was half way up the stairs on W2 and the staff told her what had happened. However, the duty nurse carried a small emergency bag for immediate life support and there was a full emergency kit available on each wing.
100. Prison Service Instruction (PSI) 3/2013 Medical Emergency Response Codes, issued in February 2013, after the man's death, requires all Governors/Directors of prisons to introduce a Medical Emergency Response Code protocol to enable staff to effectively communicate the nature of an emergency and allow them to take relevant equipment. Peterborough introduced a medical emergency code system on 22 February, so we make no recommendation about this.
101. During the resuscitation attempt, the man was first given CPR by a trained officer, followed very quickly by two fully CPR trained nurses. Oxygen, a breathing airway and a bag to push oxygen into the lungs were all available on the wing, in working order and used correctly. The ambulance crew and another paramedic arrived within 15 minutes of being called. Peterborough has a well-planned and executed fast track to get ambulance crews to the wings or to healthcare in the case of emergency and there was no delay in this case.

### **The actions of the man's personal officer**

102. The Director of Peterborough, commissioned a disciplinary investigation into the man's personal officer's completion of the man's ACCT document. The man's personal officer said that when he unlocked the man on the morning of his death, he saw through the gap in the door that he was sitting on the bed. He also said that he thought he had seen the man on the landing at around 7.30am and recorded this observation in the ACCT document. CCTV footage showed the man did not leave his cell at any time that morning. The Director decided that, although the man's personal officer's actions did not contribute to the man's death, they were, nevertheless, not up to the standard he required and the officer was therefore dismissed.
103. There is room for doubt about the impact of the officer's actions. The entry in the man's ACCT document at 7.30am meant that the hourly ACCT observation had not taken place and was already overdue. On previous occasions, the man had tied ligatures and expected to be found by staff. Had the 7.30 am entry not been made someone would have had to go to his cell to check on him. The man might have expected such a check and it is possible that if the check had been done he would have been found in time to save him.

### **Unlocking prisoners' cells in the morning**

104. During the internal investigation, another officer, who had been trained about two years earlier, said there had been no specific training on unlocking cells. He said he had learnt the process from shadowing other officers. The officer said things are quite hectic in the morning, so the staff just "crack" the doors (opening the doors so that prisoners can come out but not swinging the door open and checking the prisoner inside). He said he checks all prisoners subject to ACCT monitoring by looking through the cell flap before unlocking the door. The Sodexo investigator wrote in her report that, "unlock procedures are not clearly explained on the Initial Training Course".
105. From the evidence of a prisoner who knew the man well it seems that the man was alive at 7.36am. There is no reason not to accept the prisoner's account and therefore a check at unlock in this case would not have altered the outcome. Nevertheless, we believe it is important to check the well being of all prisoners when they are unlocked.
106. After the man's death, the Director issued an instruction to staff that all prisoners must be seen and checked when unlocking cells. In view of this, we are satisfied that appropriate action has been taken.

### **Management of the suicide and self-harm prevention procedures**

107. Prison Service Instruction (PSI) 64/2011 gives guidance and instructions to prisons about managing prisoners at risk of harm. The officer started the

ACCT process at 9.00am on 8 July, after the man told him he had tried to hang himself the night before. He correctly completed the “Concern and Keep Safe Form” section of the ACCT document and should then have passed it to the unit manager on W2 to complete the “Immediate Action Plan” within one hour, as instructed on the form. However, the officer completed the Immediate Action Plan himself. (a member of staff signed his agreement to it the following day when the first case review was held.) At interview, the officer said he always completes both these sections of the ACCT when he opens one and had never been told this was incorrect.

#### *Case reviews*

108. The man’s first case review should have been completed within 24 hours of raising the Concern and Keep Safe form (ie by 9.00am on 9 July). The review was conducted slightly outside of this parameter at 11.00am.
109. The man’s subsequent case reviews were carried out at the scheduled times. In general, they had good staff representation – nurses and wing staff were often present and a representative from the in-reach team attended some of them. When a prisoner is on ACCT support it can sometimes be helpful for them to share a cell as it forces some level of interaction and stops a person becoming isolated and inwardly focussed. The man was a standard risk for cell sharing, which meant that he could have shared a cell, but this does not appear to have been explored. It seemed to have been done successfully at Chelmsford, where staff had observed the man talking to his cell mate and playing cards with him. While we do not suggest that sharing a cell would have prevented the man taking his life, and there are reasons to believe he would have found it difficult, we consider that the case reviews should have explored it. Indeed, it is the first “factor to consider” in the page giving guidance for case reviews kept in the front of the ACCT document.
110. A senior prison custody officer in the safer custody department explained that a senior officer carries out two checks a day on each open ACCT, a manager conducts a weekly check and a safer custody check is also completed. The senior officer explained that she considers a “quality conversation” to be where a member of staff sits down and speaks to the prisoner to check how they are, whether there is anything they need and what they are planning to do that day. In general we consider that the records indicated that there was a good standard of interaction between staff and the man, reflected in the detail of the entries in the ACCT documents.

#### *Recording of observations and events in the ACCT document*

111. The man’s observation levels were not always clear. Both three per hour and two per hour were written on the front page of the ACCT for 2 August and the agreed level was not recorded in the case review note.
112. PSI 64/2011 states that as part of the day to day management of the ACCT plan, “Staff must follow the level of observations and conversations ... These must be recorded immediately or as soon as practicable thereafter”. We

consider this means that all observations should be recorded and not just the 'meaningful conversations' otherwise there is no record that checks have been completed as required. During the night, the man's observations were recorded in the on-going record but in the daytime, entries were generally where conversations or interaction had taken place and not all the observations. This is not to say that they were not carried out, but they were not always recorded.

113. The issue of recording observations was identified in a management check on 27 July and staff began to act on it, but they slipped back to recording just meaningful conversations a few days later. On 31 July and 1 August, the observations were not recorded consistently by officers and, generally, only meaningful conversations were written up. There was also confusion about whether the observations had been set three or two per hour. The same manager did another check on 2 August and again reminded staff to record their observations in the on-going record. Some of the day staff, continued just to write up meaningful conversations. We are concerned about the failure to record each observation, despite the management reminders.
114. The events of Sunday 29 July are not recorded clearly or accurately on the ACCT on-going record and could only be pieced together by the investigator by looking at several other sources of information – SystmOne, The man's wing file, the print out of cell locations and moves, the ACCT case review and the mental health in-reach paper record. Read on its own, the ACCT on-going record gives the picture that, after a shaky start at 9.10am, the man went on to have a fairly good day – sitting in his cell, writing a letter, watching television and having a laugh and a joke with the wing orderlies. In fact, at some point that morning the man was found with a ligature around his neck, so tight that it had to be cut off. The Sister admitted him into healthcare as an inpatient. A case review took place at 12.00pm, in which the man's observations were increased to three each hour and he was kept in healthcare overnight. He was seen by the member of staff from the mental health in reach team from the in-reach team and the case review recorded that she had made a referral for him to be seen by the psychiatrist as soon as possible (although as noted that referral was never made).
115. There were serious shortcomings in information sharing and recording on Sunday 29 July. Chapter 2 of PSI 64/2011 states, "information sharing is key to delivering safer custody that is co-ordinated around the needs of the individual". The chapter discusses the sharing of clinical information, which should ideally be shared with the prisoner's consent but can be done without their consent if it is considered necessary to protect the individual from risk of death or serious harm. Healthcare staff (including in-reach team members) should make entries in the ACCT on-going record when they have seen a patient. The amount of detail required will depend on individual circumstances, but it is vital that all staff involved in caring for those on ACCT are aware of meetings and appointments that have taken place. The on-going record is the means of doing this.

116. In view of the various weaknesses highlighted in the management of the risk of suicide and self-harm, we make the following recommendation:

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

- **Completing the ACCT process within the specified timescales and relevant staff completing individual sections of the ACCT document.**
- **Considering whether cell sharing is appropriate and documenting the reasons for decisions.**
- **Effective liaison between the safer custody and healthcare departments.**
- **Clearly recording observation levels on the front of the ACCT document, in the note of the case review meeting and the on-going record.**
- **Recording all observations and conversations with prisoners in the on-going record.**

#### **The man's location**

117. The man spent the vast majority of his time on W2 wing, the vulnerable prisoner unit. He told staff he found it hard to cope with both the noise on the wing and the noise in his head. He was moved to a quieter part of the wing but he continued to say that he did not like the noise. The man often asked to stay in the healthcare centre but did not stay for more than one night each time before being discharged back to W2.
118. The prison GP said admission to the healthcare centre would be like a GP admitting a patient to hospital in the community. He believed it should not be a reaction to a self-harm episode in itself. Prisoners who are subject to constant supervision (which the man was not) are monitored in the inpatient unit. The GP explained that prisoners are locked up for long periods in healthcare and isolation is often detrimental to a patient because they do not have the same opportunity to associate with other prisoners, take exercise or go to work. It seems that isolation was part of the attraction for the man. He did not take part in the regime on the wing, he did not go to outdoor exercise, or seem motivated to have a job and very rarely associated with anyone else. He led a very isolated existence apart from his interaction with staff. This would have been the same whether he was in the healthcare centre or on the wing.
119. The man also asked to go to the separation and care unit on 2 August in order to avoid going back onto the wing. However, PSI 64/2011 makes it clear that a prisoner on an open ACCT should be held in the segregation unit only in exceptional circumstances and where other options have been considered but discounted. The request was an indication of how much the man wanted to avoid going back to W2. While it would have been preferable to have seen some recorded discussion about what this meant for the man we are satisfied that W2 was an appropriate location for the man in the prison.

120. All the cells in Peterborough were designed as “safer cells” that is cells with minimal ligature points. The man attached his ligature to the medicine storage locker designed to keep medication secure. These lockers were fixed to the wall near the shelving unit and had been in place for some years. No one had used them before as means of attaching a ligature. The Director reviewed this after the man’s death and they were detached from the walls a few days later. It is worthy of note that the Director acted so quickly to remove this ligature point from cells.

### **Predicting and preventing the man’s actions on 10 August**

121. In the last ACCT review on 5 August, another Senior Officer described the man as “completely different”. He was making jokes and having a laugh. He had also been out of his cell that weekend and played pool and table tennis. This was a complete change to his usual demeanour.
122. One of the prison doctors, described a parasuicide person as someone who makes multiple attempts at suicide, but not necessarily to a level to try to kill themselves. In his medical opinion, the suicidal patient is often not on an ACCT plan because they do not want to express the fact that they are going to kill themselves as their intent is very significant. He believes that a parasuicide person is more likely to be monitored under ACCT procedures than someone with definite suicidal intent.
123. The GP considered that the man’s attempts at ligature from early July onwards were parasuicide acts. This did not negate the risk that he presented, because someone who regularly gets to a parasuicide level believes they will not actually end up killing themselves which is very risky. The GP said the intent is not necessarily to kill themselves, but the risk of them doing so increases as time goes on. He added that someone with parasuicide intent might change to become actively suicidal. One of the big signs of that change is the person significantly improving in their presentation and ACCT support ending over a short space of time. This can mask suicidal intent to stop ACCT monitoring so they can carry out their plans more easily. This is a pattern we have seen in some previous investigations. It is of note that the man said at the review on 5 August that he no longer had any suicidal thoughts which could have been seen as a warning sign.
124. We cannot know whether the man intended to end his life on the morning of 10 August. As he had been found with ligatures on previous occasions, he was always at risk of suicide, either because he meant to carry it out or because staff would not find him in time. We are satisfied that the prison appropriately identified him as a risk and put in place suicide prevention procedures to try to mitigate the risk. Despite the apparent recent change in his demeanour there was little to indicate his intentions on 10 August and we do not consider that prison staff could reasonably have predicted or prevented his action that morning. However, as noted, it is a concern that the man might have been expecting an ACCT check which did not happen as the man’s personal officer wrongly observed that he had seen the man at 7.30am.



## RECOMMENDATIONS

1. The Director and Healthcare Manager should ensure that the mental health in-reach team requests and obtains a comprehensive handover when a prisoner with known complex mental health problems transfers to Peterborough.
2. The Director and Healthcare Manager should implement standard depression screening and assessment questionnaires for prisoners diagnosed with depression, at the initial medical assessment and during consultations, which should be used to assess and record levels of depression and responses to treatment.
3. The Healthcare manager should ensure that there is effective and clear liaison between the primary care providers and the mental health in-reach teams which prioritises urgent referrals to a psychiatrist for prisoners with high risk behaviour.
4. The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Completing the ACCT process within the specified timescales and relevant staff completing individual sections of the ACCT document.
  - Considering whether cell sharing is appropriate and documenting the reasons for decisions.
  - Effective liaison between the safer custody and healthcare departments.
  - Clearly recording observation levels on the front of the ACCT document, in the note of the case review meeting and the on-going record.
  - Recording all observations and conversations with prisoners in the on-going record.

# ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Director and Healthcare Manager should ensure that the mental health in-reach team requests and obtains a comprehensive handover when a prisoner with known complex mental health problems transfers to Peterborough.	Accepted	Where evidence of prior active of In-Reach work is taking place at previous prisons the team will obtain an update within two working days or escalate as a clinical concern that needs to be rectified, to the Head of Healthcare.	December 2013  Completed	
2	The Director and Healthcare Manager should implement standard depression screening and assessment questionnaires for prisoners diagnosed with depression, at the initial medical assessment and during consultations, which should be used to assess and record levels of depression and responses to treatment.	Accepted	<p>Accepted by PPO office to re-word recommendation 2 as below:</p> <p><i>“The Director and Healthcare Manager should implement standard depression screening and assessment questionnaires for prisoners diagnosed with depression, at the initial medical assessment and during consultations, which should be used to assess and record levels of depression and responses to treatment.”</i></p> <p><b><u>Response</u></b></p> <p>Where a GP identifies there is a need for depression screening and assessment questionnaire the Mental Health In Reach team (who provide primary and secondary mental health services at HMP/YOI Peterborough) should be asked to carry out standard depression an screening assessment questionnaires and the outcomes should be actioned and recorded on system-one and in the Mental Health In Reach files.</p>	Completed	

3	<p>The Healthcare manager should ensure that there is effective and clear liaison between the primary care providers and the mental health in-reach teams which prioritises urgent referrals to a psychiatrist for prisoners with high risk behaviour.</p>	Accepted	<p>HMP/YOI Peterborough have introduced the Complex and Additional Needs Policy to ensure risks are assessed to prioritise urgent referrals to psychiatrists.</p>	Completed	
4	<p>The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <p>a) Completing the ACCT process within the specified timescales and relevant staff completing individual sections of the ACCT document.</p> <p>b) Considering whether cell sharing is appropriate and documenting the reasons for decisions.</p> <p>c) Effective liaison between the safer custody and healthcare departments.</p> <p>d) Clearly recording observation levels on the front of the ACCT document, in the note of the case review meeting and the on-going record.</p>	Accepted	<p>The standards are in line with national policy and we have included all the elements listed (a to e) as part of our ACCT management checklist that was introduced in November 2013.</p> <p>Additionally, a notice to staff and review of issues are discussed in the safer custody meetings.</p>	<p>Completed</p> <p>Completed</p>	

	e) Recording all observations and conversations with prisoners in the on-going record				
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