

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Michael Forster a prisoner at HMP Leicester on 21 November 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Forster died in hospital on 21 November 2016 after he was found hanged in his cell at HMP Leicester two days earlier. He was 26 years old. I offer my condolences to Mr Forster's family and friends.

This is a sad case of a man who presented as paranoid and delusional. While some positive, supportive actions were taken by the prison to help Mr Forster, I am concerned that staff did not always fully consider events that indicated Mr Forster's risk of suicide and self-harm had increased and did not comply with some basic aspects of Prison and Probation Service suicide and self-harm prevention procedures. I am particularly concerned that I raised similar issues in my last investigation at Leicester.

There were also deficiencies in the emergency response, including a delay before anyone opened Mr Forster's cell or called for emergency medical assistance.

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

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

**August 2017**

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# Summary

## Events

1. On 4 October 2016, Mr Michael Forster was remanded to HMP Leicester. It was his first time in prison. He had recently cut his neck and, when remanded to custody, said he would take his life that night. Reception staff began suicide and self-harm procedures, known as ACCT but no one referred Mr Forster to the mental health team.
2. Later that day a supervising officer held the first ACCT case review. No one else was present and she did not create a caremap, a mandatory requirement of the first case review.
3. Over the following weeks, Mr Forster frequently expressed delusions that he would be killed – sometimes by his family– or deported to face the death penalty. On another occasion, he told his family that they would not see him again as he intended to take his life. He made cuts to his neck and made a ligature. Prison staff did not always discuss these incidents at ACCT case reviews, and always considered that Mr Forster was at low risk of harming himself.
4. A prison psychiatrist requested an assessment to determine whether Mr Forster should transfer to a secure hospital. Specialist commissioners did not receive the initial referral, so the mental health team manager resent it several weeks later. Mr Forster was still awaiting assessment when he died.
5. Prison staff were required to check Mr Forster twice an hour but on the morning of 19 November the night patrol officer went over an hour without observing him. At 4.37am, he found Mr Forster kneeling on the floor with a ligature around his neck, and told us he thought Mr Forster was about to hang himself. He did not open the cell or call for emergency assistance. When other staff arrived at 4.38am, they opened the cell, realised that Mr Forster had already hanged himself, and began cardiopulmonary resuscitation. They did not call for emergency assistance until 4.41am. Paramedics arrived and took Mr Forster to hospital. He died in hospital on 21 November.

## Findings

6. Mr Forster appeared anxious and paranoid at Leicester. We are not satisfied that enough was done to address his risk of suicide and self-harm. A number of key aspects of ACCT procedures aimed at reducing risk, including holding multidisciplinary case reviews and setting meaningful caremap actions, were not fulfilled. Staff did not always fully consider incidents that might have indicated that Mr Forster was at raised risk, and observations were not always carried out at the specified intervals.
7. We are concerned that no one referred Mr Forster to the mental health team when he arrived at Leicester.
8. We also found that staff took too long to go into Mr Forster's cell and call for medical assistance when they found him hanging, and there was a delay in the nurse arriving.

## Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
  - ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.
  - ACCT caremap actions are initiated at the first case review, are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.
  - Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.
  - Observations are carried out as directed.
- The Head of Healthcare should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
  - Night staff enter cells as quickly as possible in a life-threatening situation.
  - Night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.
  - Healthcare staff are able to reach prisoners as quickly as possible whenever there is an emergency at night.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Leicester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Leicester on 28 November 2016. He obtained copies of relevant extracts from Mr Forster's prison and medical records.
11. The investigator interviewed eight members of staff at Leicester on 9-10 January 2017.
12. NHS England commissioned a clinical reviewer to review Mr Forster's clinical care at the prison.
13. We informed HM Coroner for Leicester City and South Leicestershire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Forster's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Forster's mother did not raise any issues for the investigation to address.
15. Mr Forster's mother received a copy of the initial report. She did not make any comments.

# Background Information

## HMP Leicester

16. HMP Leicester is a local prison that holds 325 men. It primarily serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Leicestershire Partnership NHS Trust provides healthcare services at the prison.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Leicester was in October 2015. Inspectors reported that the level of self-harm was five times that of other local prisons. They found that the quality of ACCT management was not consistently good, care planning was weak and did not contain meaningful objectives for prisoners. Inspectors also reported that mental health nurses spent a significant proportion of their clinic time attending ACCT reviews and responding to mental health crises, leaving little time to manage prisoners on their caseload effectively.

## Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to January 2016, the IMB reported that the ACCT process had become more focused on those in crisis and there were stronger links between the mental health and safer custody teams. However they reported that the number of open ACCT documents had increased, which meant it was difficult for staff to manage the required number of observations.

## Previous deaths at HMP Leicester

19. Mr Forster is the third prisoner to die at Leicester since January 2015, and the second to take his own life. In our investigation into the most recent self-inflicted death, we found that ACCT caremap actions were poor and did not effectively address the prisoner's concerns, and that observations were not always carried out at the specified intervals.

## Assessment, Care in Custody and Teamwork

20. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move

around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **New Psychoactive Substances (NPS)**

21. NPS, previously known as 'legal highs', are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
22. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.
23. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

# Key Events

## HMP Leicester

24. Mr Michael Forster was remanded to HMP Leicester on 4 October 2016, charged with a violent offence against his ex-wife. It was his first time in prison. Mr Forster's person escort record (a form that accompanies prisoners on all journeys to communicate information including about risk factors) said that he had cut his neck two days earlier and was at high risk of suicide or self-harm. It also said that Mr Forster had depression and had said, "I'm gone tonight, I mean it" when he was remanded. A member of court staff completed a suicide and self-harm warning form, which repeated this information. Reception staff began ACCT procedures when Mr Forster arrived at Leicester.

## ACCT procedures

25. A nurse assessed Mr Forster and recorded that he had tried to stab himself in police custody. She noted that, while Mr Forster's community GP had prescribed citalopram (an antidepressant). Mr Forster said he had not taken the medication but would like to start. The nurse did not complete a referral to the mental health team. A prison GP prescribed a course of citalopram.
26. Reception staff arranged for Mr Forster's brother, who was also in custody at Leicester, to visit him. They asked Mr Forster if he would like to share a cell with his brother, but he declined.
27. Later that afternoon, a Supervising Officer (SO) assessed Mr Forster as part of ACCT procedures. She recorded that Mr Forster had not recently tried to harm himself, and told us that this was what Mr Forster told her at the assessment. She did not challenge Mr Forster's statement. She also recorded that Mr Forster had no current suicidal thoughts or intentions and that the key issues were to "keep him occupied" and to maintain ties with his brother.
28. The SO then held the first ACCT case review. Prison Service Instruction (PSI) 64/2011 has a mandatory instruction that the first case review must be chaired by a residential manager or the ACCT case manager and that the assessor should attend with others including a member of healthcare staff. If those invited cannot attend in person, they can exceptionally give a written account of their input. Only the SO and Mr Forster attended. The SO said that healthcare staff were not invited because the nurse had already seen Mr Forster and she had spoken to her about the outcome of their consultation.
29. The SO recorded that Mr Forster was more settled than when he arrived and said he did not want to take his life, but was apprehensive about being in prison. She recorded that he was at low risk of suicide or self-harm. Prison staff recorded Mr Forster's risk as low at every subsequent ACCT case review. The SO did not complete a caremap, a mandatory requirement of the first case review. She said this was because Mr Forster had not raised any issues and because he was still in the early stages of his time in custody. She set ACCT observations at a minimum of one per hour and that prison staff should have at least three conversations with Mr Forster each day.

30. On 6 October, the ACCT case manager led an ACCT case review. (He has since been suspended from the Prison Service, for matters unrelated to Mr Forster. We wrote to him to request an interview, but he did not respond.) Two mental health nurses attended the case review. Mr Forster said he was doing “okay” and had not taken his antidepressant in the community. The case manager entered one action on the ACCT caremap: for Mr Forster to see a GP to prescribe medication. A nurse later recorded that Mr Forster had already been prescribed this medication and she would tell him this.
31. On 7 October, an officer identified that no one had referred Mr Forster to the mental health team. After discussion, the mental health team booked an appointment with the visiting psychiatrist.
32. On 12 October, Mr Forster’s solicitor telephoned the prison. He said that Mr Forster had written to his father and said he would kill himself after Christmas. A custodial manager spoke to Mr Forster and recorded that he was trying to adjust to being in prison for the first time and was happy to work with the mental health team.
33. On the same day, an officer requested an urgent mental health assessment after reports of Mr Forster’s “bizarre and unpredictable” behaviour. A nurse assessed him that afternoon and recorded that Mr Forster believed that the referendum on the UK’s membership of the European Union was actually a vote to determine whether he should be sent to the United States of America to face the death penalty. Mr Forster said he believed he would be sent to the USA at Christmas. He also said he would “love to self-harm”.
34. On 13 October, a SO and the nurse held an ACCT case review. The SO recorded that the mental health team had referred Mr Forster to a psychiatrist. She reduced the number of conversations required to two per day. There is no record of any discussion of the events of the previous day.
35. On 14 October, a psychiatrist assessed Mr Forster, and recorded that Mr Forster believed he would no longer be sent to death in the USA but instead believed he would be “slaughtered” at Christmas. He recorded that while he was unsure of a diagnosis, Mr Forster’s beliefs were “plausibly psychotic”. He requested a ‘gatekeeping’ assessment to determine whether Mr Forster should transfer to a secure hospital. The psychiatrist did not prescribe any additional medication. (A nurse emailed commissioners at NHS England on 19 October to ask for an assessment.)
36. The ACCT case manager chaired an ACCT case review on 16 October, with Mr Forster and a wing officer present. He recorded that Mr Forster was worried about his mental health, and added one action to the ACCT caremap: that he would refer Mr Forster to the mental health team. (It is unclear whether he referred Mr Forster again, and no one from the mental health team assessed him for over a week.)
37. On 18 October, Mr Forster moved to a cell next to the segregation unit so that he could be in a neighbouring cell to his brother who was segregated at the time. Mr Forster was allowed to help clean the segregation unit so he could speak to his brother during the day.

38. At an ACCT case review on 22 October, a custodial manager recorded that Mr Forster appeared relaxed, had regular contact with his brother, and got on well with staff. There was no healthcare representative at the case review.
39. The case manager chaired an ACCT case review on 24 October. Again, there was no healthcare representative at the review. He recorded that Mr Forster appeared worried about an upcoming court appearance. Later that afternoon, a custodial manager spoke to Mr Forster and recorded that he was afraid he would be “slaughtered” on Halloween.
40. On 27 October, the case manager chaired an ACCT case review with a nurse and an officer. The nurse recorded in the medical record that Mr Forster said he was convinced he would be slaughtered at 12.05am on Halloween, and he repeated his belief that he would be sent to the USA to face the death penalty. The case manager recorded that Mr Forster said he had smoked ‘Mamba’ (a new psychoactive substance, formerly known as ‘legal highs’). He did not record any of these issues in the record of the case review, and did not change Mr Forster’s level of risk or observations. There is no evidence that Mr Forster smoked new psychoactive substances on any other occasion.
41. On 30 October, Mr Forster made small cuts to his throat with a razor blade. The nurse who treated the wound recorded that he was preoccupied with thoughts that he would be killed on Halloween.
42. An SO chaired an ACCT case review on 31 October with an officer. He recorded that he had invited a nurse to attend, but he was unable to do so. Mr Forster told him that he would be “chopped up” that night and said he had thought about harming himself to avoid this. They did not discuss the cuts Mr Forster had made the previous day. The SO made no change to Mr Forster’s level of risk or observations. He said this was because he did not think there was an immediate risk that Mr Forster would take his life, that he seemed to laugh when he spoke about being hurt that night, and because the recent cuts Mr Forster had made were superficial.
43. On 3 November, Mr Forster’s brother was transferred to another prison. Mr Forster had a scheduled appointment with the psychiatrist on 4 November, but his appointment was rescheduled as other patients with more urgent needs took priority.
44. On 4 November, a custodial manager chaired an ACCT case review, with a nurse and an officer. He recorded that Mr Forster believed he would be tortured either on 5 November or Christmas Day. He told us that his impression was that Mr Forster believed this to be true. He did not make any change to Mr Forster’s level of risk or observations.
45. On 9 November, Mr Forster’s father and sister visited him. Afterwards, Mr Forster’s sister told an operational support grade (OSG) that Mr Forster had said this was the last time they would see him as he intended to hang himself. The OSG told a safer custody manager, who advised the case manager of Mr Forster’s comments before his scheduled ACCT case review that afternoon.

46. The case manager held the ACCT case review with a nurse. He recorded that Mr Forster said he was “okay” but wanted to spend more time out of his cell. He did not record any discussion of Mr Forster’s comments at his visit. The case manager made no change to Mr Forster’s level of risk or observations. He made one addition to the caremap: for Mr Forster to move landing. He recorded that he would speak to safer custody staff about this.
47. After the ACCT review, the OSG spoke to the safer custody manager again and said she was concerned that the case manager had not increased Mr Forster’s level of observations. He agreed, and increased the observations to a minimum of two per hour.
48. On 9 November, the nurse re-sent the gatekeeping referral, as they had not yet received a response from the service commissioners. The commissioners told her that they had not received the original referral. They later told her that they would discuss Mr Forster at their allocation meeting on 21 November.
49. On 14 November, an SO held an ACCT case review with a nurse. Before the review, they found a ligature on the floor of Mr Forster’s cell. The SO said she showed the ligature to Mr Forster but he did not talk to her about it. She said he appeared paranoid and said he thought his family and others intended to kill him. The SO recorded that both she and the nurse thought Mr Forster’s mental health had deteriorated. She did not change Mr Forster’s level of risk or observations. After the review, the nurse asked that healthcare staff book Mr Forster an appointment with the psychiatrist.
50. On the same day, prison staff agreed that Mr Forster should be given ‘vulnerable prisoner’ status. The Head of Safer Custody told us that they were concerned that Mr Forster would struggle to cope on the prison’s main residential wing and might be a target for bullying. Giving him vulnerable prisoner status allowed him to remain in the same cell on the smaller, quieter unit, where he lived.
51. On 17 November, the case manager and a nurse held an ACCT case review. The case manager recorded that Mr Forster did not engage with the review and told them he just wanted to sleep. He did not change the level of risk or observations.
52. On 18 November, the psychiatrist reviewed Mr Forster. He recorded that Mr Forster said he would die on various future dates, and that other people received messages about him on television. She concluded that Mr Forster was floridly psychotic (experiencing full-blown hallucinations or delusions) and prescribed olanzapine (anti-psychotic medication).
53. At around 2.25am on 19 November, the night patrol officer completed an ACCT observation. Mr Forster was awake, so he spoke to him. (He said it was not unusual for Mr Forster to be awake, watching television, until the early hours of the morning.) Mr Forster said he could not sleep and asked for a tea bag. At around 2.40am, he brought him one.
54. The night patrol officer recorded that when he visited the cell at 3.01am, Mr Forster was having a drink and appeared wide awake. It does not appear from CCTV footage that this observation took place.

55. At 3.20am, the night patrol officer completed an observation. He recorded that Mr Forster was watching television.
56. The night patrol officer did not return to Mr Forster's cell until 4.34am. He told us that he spent this time catching up on paperwork because he had dealt with two difficult and time-consuming prisoners earlier in the night. He said he lost track of time and had not intended to miss Mr Forster's observations.
57. The night patrol officer spent 40 seconds at Mr Forster's cell at 4.34am. He said that Mr Forster was sitting on his bed with the television turned off. He returned to the office to write up the observation.
58. The night patrol officer said he thought there was something unusual about Mr Forster's presentation. He therefore returned to the cell at 4.37am. He said he found Mr Forster kneeling at the far end of the cell and leaning on a small table. He said Mr Forster had a blanket tied to him. His impression was that Mr Forster was initiating a ligature but had not yet hanged himself. He called to Mr Forster, but received no response.

### **Emergency response**

59. The night patrol officer then left the cell and radioed an officer for help. Shortly afterwards, he radioed for any staff to attend and said Mr Forster had a ligature around his neck. He did not use an emergency code, as he said he did not think Mr Forster was hanging. At night, officers carry a cell key in a sealed pouch that they can break and use to enter a cell in an emergency, subject to a risk assessment. He said he did not open the cell before colleagues arrived as he thought Mr Forster was alive and he did not think it would be safe to enter on his own.
60. At 4.38am, a custodial manager and three officers arrived on the landing and opened Mr Forster's cell, and found he had tied the ligature to the window bars and hanged himself. They removed the blanket and laid Mr Forster on the floor. Mr Forster had no pulse so the custodial manager began cardiopulmonary resuscitation. At 4.40am, an officer radioed for healthcare assistance and, at 4.41am, she radioed a code blue medical emergency, indicating a life-threatening situation. The control room operator called an ambulance immediately.
61. The emergency response nurse does not have keys at night and has to wait in the healthcare centre until the night manager or their assistants collect them to attend a medical emergency. An officer collected a nurse and arrived at Mr Forster's cell at 4.44am. The nurse applied oxygen and attached a defibrillator, which found no shockable heart rhythm.
62. The staff continued chest compressions until paramedics arrived at 4.52am. The paramedics re-established a pulse and, at around 5.40am, took Mr Forster to the intensive care unit at hospital. Mr Forster died at 3.20am on 21 November.

### **Contact with Mr Forster's family**

63. Prison staff tried unsuccessfully to contact Mr Forster's family by telephone when he was taken to hospital. They therefore asked the police to visit Mr Forster's

family, which they did at around 8.30am on 19 November. Mr Forster's family visited him in hospital later that morning, and were present when he died on 21 November. Leicester contributed to the cost of Mr Forster's funeral in line with Prison Service instructions.

### **Support for prisoners and staff**

64. On 19 November, a custodial manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
65. The prison posted notices informing other prisoners of Mr Forster's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Forster's death.

### **Post-mortem report**

66. A post-mortem examination established the cause of death as hypoxic/ischaemic brain injury due to hanging.

# Findings

## Management of risk of suicide and self-harm

67. Prison staff appropriately began ACCT procedures when Mr Forster was remanded to Leicester. While some positive, supportive actions were taken – such as allocating Mr Forster a cell next to his brother – we are concerned that the ACCT procedures were poorly managed and were not in line with Prison and Probation Service policy. While this might not have affected the eventual outcome, it would have given prison managers and staff a better chance of producing a co-ordinated and effective care plan, aimed at addressing his issues and reducing his risk.
68. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It requires ACCT case reviews to be multidisciplinary, where possible, and that a healthcare representative must attend the first case review. No one from the healthcare team attended the first case review. We are concerned that there was no healthcare representative at nearly half of the case reviews, particularly in light of Mr Forster's mental health issues.
69. A caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview. The caremap should set actions aimed at reducing the prisoner's risk to himself, and set a timescale to complete these actions. An SO did not complete a caremap at the first case review. When the case manager created a caremap at the second case review the action set, and that added at the fourth case review, amounted to referrals to services only.
70. Prison staff judged Mr Forster's risk of suicide and self-harm as low at every ACCT case review. At Leicester, Mr Forster often spoke of delusions that he would be killed – sometimes by his family – or deported to face the death penalty. He told his family that he intended to take his life. Mr Forster also cut his neck and made a ligature. He said he had smoked 'Mamba', a new psychoactive substance, and use of these substances is known to increase risk of suicide and self-harm. Staff did not always discuss these incidents at ACCT case reviews. No one raised his level of risk from low and the frequency of observations was only increased once, and then outside of a case review and due to the commendable persistence of a junior member of staff. Guidance in the ACCT document is that risk is raised when there is evidence of mental disorder, the situation experienced is painful, and there is current self-harming behaviour. We consider that staff underestimated Mr Forster's risk of suicide and self-harm.
71. The night patrol officer should have observed Mr Forster twice an hour, but the checks were not completed at the required frequency. He did not complete a check from 3.20am until 4.34am, and the check he recorded at 3.01am does not appear from CCTV to have taken place. After Mr Forster's death, prison managers gave him advice and guidance as to his future conduct.
72. In a PPO Learning Lessons Bulletin, published in March 2015, about the self-inflicted deaths of prisoners in 2013-14, we found that staff should ensure that

prisoners at risk of suicide and self-harm are managed in line with national instructions and guidance. We found that this should include holding multidisciplinary case reviews, completing relevant caremap objectives, and ensuring observations follow the prescribed level.

73. Our findings echo those in our investigation into the most recent self-inflicted death at Leicester in September 2015, in which we found that ACCT caremap actions did not effectively address the prisoner's concerns, that staff did not always consider events that might affect his risk, and that observations were not completed at the required frequency. We make the following recommendation:

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

- **ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.**
- **ACCT caremap actions are initiated at the first case review, are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.**
- **Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.**
- **Observations are carried out as directed.**

### Clinical care

74. A nurse sent a gatekeeping referral to NHS specialist commissioners on 19 October. She told us that she re-sent the referral on 9 November because the commissioners said they had not received the original. Since Mr Forster's death, NHS commissioners now provide feedback on the status of all gatekeeping referrals every Friday to ensure no one is missed. We do not therefore make a recommendation.
75. Mr Forster's person escort record indicated that he had recently harmed himself, was diagnosed with depression and threatened to take his life that night. While staff appropriately began ACCT procedures, we are concerned that a nurse did not refer Mr Forster for a mental health assessment. We make the following recommendation:

**The Head of Healthcare should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate.**

### Emergency response

76. We have a number of concerns about the emergency response on 19 November. At night, officers have a key in a sealed pouch for use in an emergency. Prison Service Instruction 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for

opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

77. The night patrol officer said that Mr Forster appeared to have begun the process of hanging himself. He did not open the cell as he said he did not think it would be safe to do so before colleagues arrived. We recognise that it can be difficult for staff in such situations to make instant decisions but when there is a potentially life threatening situation, it is essential to act quickly. He thought that Mr Forster was about to hang and, in these circumstances, we would normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life.
78. PSI 03/2013 on Medical Emergency Response Codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.
79. Leicester's local instruction on emergency response codes (Emergency Response Protocol, March 2016) instructs the use of the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when the prisoner has difficulty breathing or is unconscious.
80. The night patrol officer did not radio a code blue medical emergency as he said he did not think Mr Forster was hanging at that stage. Nevertheless, he felt that Mr Forster was beginning this process and, if he was not prepared to open the cell to prevent this, he should have realised that Mr Forster could quickly become unconscious or stop breathing, and he should therefore have used the appropriate emergency code. There was a delay of three minutes after the cell was opened before anyone radioed the appropriate emergency code, despite staff finding Mr Forster with no pulse. This would have alerted staff throughout the prison, including the emergency response nurse, and signalled the control room to call an ambulance immediately.
81. At night, healthcare staff do not have keys to enter the prison wings and they have to wait for the night manager or their assistants to take them to the scene of an emergency. This led to a delay before the nurse arrived at Mr Forster's cell. We consider prisons should do everything they can to ensure that the preservation of life is placed over security arrangements and this practice caused an inherent delay.
82. We cannot say whether any of these delays affected the outcome for Mr Forster. Nevertheless, it is important that prison staff understand their roles in a

medical emergency, as early intervention when someone is found hanging might save their life. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:**

- **Night staff enter cells as quickly as possible in a life-threatening situation.**
- **Night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.**
- **Healthcare staff are able to reach prisoners as quickly as possible whenever there is an emergency at night.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations