

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig Hughes a prisoner at HMP Birmingham on 11 June 2017

A report by the Prisons and Probation Ombudsman

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 Craig Hughes was found hanged in his cell at HMP Birmingham on 11 June 2017. He was 42 years old. I offer my condolences to Mr Hughes' family and friends.

Mr Hughes had a history of self-harm and was diagnosed with a personality disorder and schizophrenia. He was supported under Prison Service suicide and self-harm prevention measures (known as ACCT) on two occasions before his death but we found deficiencies in how these procedures were managed.

Five days before his death, Mr Hughes told a nurse that he had contemplated self-harm but the nurse assessed him as mentally stable and did not consider monitoring him under ACCT. Given Mr Hughes' known risk factors for suicide and self-harm, I am concerned that the nurse did not consider supporting Mr Hughes using ACCT procedures.

I am also concerned that healthcare staff completed Initial Segregation Health Screens inaccurately, which meant that important decisions to keep Mr Hughes in segregation were based on inaccurate information.

Mr Hughes had been held in segregation for just over 72 hours when he was found hanging. Because Mr Hughes had not been segregated under Prison Rule 45 (for the maintenance of good order or discipline) for the entire 72 hours, Prison Service policy did not require a Segregation Review Board to be held during this time. I am concerned that, as a consequence, the decline in Mr Hughes' mental health was not identified. I have made a recommendation to close what seems to me to be a gap in Prison Service policy.

I also consider that it was inappropriate for an officer who found Mr Hughes hanging in his cell to be asked to support other officers, rather than being offered support himself.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

January 2019

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Summary

Events

1. On 7 February 2017, Mr Craig Hughes was recalled to prison for threatening probation staff and was sent to HMP Birmingham. Mr Hughes was diagnosed with borderline personality disorder and schizophrenia. He had self-harmed numerous times during his time in custody and had a history of drug abuse, both in and out of prison.
2. Staff at Birmingham monitored Mr Hughes under Prison Service suicide and self-harm procedures (known as ACCT) on two occasions, after he heard voices and cut himself. Staff held regular ACCT reviews, though healthcare staff were absent for most of them. During his second ACCT (which was closed on 2 May), staff did not hold an assessment interview, create a caremap or hold a post-closure interview.
3. On 6 June, during a mental health review, Mr Hughes said he had contemplated self-harm the night before but did not have any current thoughts of taking his life or self-harming. The nurse considered that his mental state was stable and did not consider opening an ACCT.
4. On the morning of 8 June, after punching an officer, Mr Hughes was taken under restraint to the Care and Separation Unit (CSU). He hurt his wrist during the incident. A prison GP thought it might be fractured and requested an X-ray but there were insufficient staff available to escort Mr Hughes to hospital. His wrist was not X-rayed before he died.
5. Nurses completed Initial Segregation Health Screens for Mr Hughes on 8 and 9 June but recorded incorrectly that he had not self-harmed in custody and was not on antipsychotic medication. Prison managers authorised Mr Hughes' segregation using this incorrect information.
6. At 9.40am on 11 June, during a medication round, Mr Hughes was found hanging in his cell in the CSU. A nurse called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) and an ambulance was called immediately. Officers cut down Mr Hughes and nurses started cardiopulmonary resuscitation (CPR). Paramedics continued resuscitation attempts at 9.49am and took Mr Hughes to hospital at 10.16am. They were delayed both entering and leaving the prison. The ambulance arrived at the hospital at 10.32am but at 10.35am a hospital doctor declared that Mr Hughes had died.

Findings

Segregation

7. Mr Hughes had been segregated for over 72 hours when he was found hanging. If he had been segregated under Prison Rule 45 throughout this period, the prison would have been required to hold an Initial Segregation Review Board within 72 hours. This requirement did not apply in Mr Hughes' case because the first 29 hours of his segregation had been authorised under Prison Rule 53(4).

We consider that an Initial Segregation Review Board should take place within 72 hours of a prisoner's segregation, regardless of which Prison Rule applies to the segregation.

8. We are also concerned that nurses completed inaccurate Initial Segregation Health Screens, upon which decisions to keep Mr Hughes in segregation were based.

Assessment of Mr Hughes' risk of suicide and self-harm

9. We are concerned that in the case of the ACCT opened in April, an assessor did not complete an assessment interview, healthcare staff did not attend any of the case reviews, the case manager did not create a caremap, the quality of staff observations was poor and a post-closure interview was not held.
10. We are also concerned that a nurse did not open an ACCT on 6 June when Mr Hughes said that he had contemplated self-harm the night before. We consider that she gave too much weight to Mr Hughes' own assertion that he no longer wanted to take his life or self-harm, rather than assessing his known risk factors.

Clinical care and substance misuse

11. The clinical reviewer considered that the physical and mental healthcare that Mr Hughes received at Birmingham was largely equivalent to that which he could have expected to receive in the community. However, we agree with the clinical reviewer that the prison's inability to escort Mr Hughes to hospital for an X-ray, after a GP suspected that he had fractured his wrist, was not equivalent to the standard of care that he could have expected to receive in the community.
12. We are concerned that, on two occasions, nurses thought that Mr Hughes was under the influence of an illicit substance. While we are satisfied that they treated the physical effects appropriately, we are concerned that neither nurse referred him to the substance misuse team.

Emergency response

13. Paramedics experienced a delay of six minutes in entering the prison and were delayed for 11 minutes before they were cleared to leave. Given that any delay in providing emergency life support to a prisoner could be critical, these delays were unacceptable.

Staff support

14. Following Mr Hughes' death, one of the officers who found Mr Hughes hanging, was asked to support the officers who were with Mr Hughes when he died. We consider it was inappropriate for this officer to be asked to provide support when he himself needed support from the care team.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners held in the CSU in line with national guidelines, including that:
 - Initial Segregation Review Boards are held within the first 72 hours of a prisoner being placed in segregation, regardless of the initial reason for segregation.
 - Initial Segregation Health Screens are completed accurately.
 - Prisoners are provided with sufficient distraction activities, such as a radio or in-cell hobbies, unless there are overriding security concerns.
- The Director and Head of Healthcare should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including:
 - Having a clear understanding of their responsibility to share information about a prisoner's risk of suicide and self-harm and start ACCT procedures when appropriate.
 - Assessing a prisoner within 24 hours of the ACCT being opened. The assessor should complete the assessment based on all available information if a prisoner has refused to engage in the assessment.
 - Setting ACCT caremap actions which are specific, meaningful and aimed at reducing prisoners' risks to themselves.
 - Completing ACCT ongoing records fully and accurately, including details of conversations and interactions with prisoners. Purely observational entries should be kept to a minimum.
 - Ensuring post-closure reviews take place at the proper time and take into consideration events since the closure of the ACCT.
- The Director and Head of Healthcare should ensure that where healthcare staff request an X-ray, the prisoner is escorted to hospital as soon as possible unless there are properly justified, exceptional and fully recorded reasons.
- The Director and Head of Healthcare should ensure that prisoners who use illicit substances are referred to drug treatment services and warned about the dangers and risks to health.
- The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, ensuring that there are no delays in directing or discharging ambulances.
- The Director should ensure that after a death in custody all staff, including staff who are members of the care team, are offered appropriate and timely support from someone unconnected to the incident.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator visited HMP Birmingham on 19 June. He obtained copies of relevant extracts from Mr Hughes' prison and medical records.
17. NHS England commissioned a clinical reviewer to review Mr Hughes' clinical care at the prison.
18. The investigator interviewed 18 members of staff at Birmingham on 24, 25 and 26 July and 31 August. He also interviewed three members of staff by telephone on 29 August, 15 September and 28 September. The clinical reviewer accompanied the investigator for five of the interviews on 25 July and one interview on 31 August.
19. We informed HM Coroner for Birmingham and Solihull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. One of the Ombudsman's family liaison officers contacted Mr Hughes' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted information about what had happened to Mr Hughes and whether there was anything to explain why he had taken his own life.
21. The investigator also contacted Mr Hughes' father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He was concerned that paramedics were delayed reaching Mr Hughes, that an injury to his wrist was not treated correctly and that inaccurate information had been given by prison staff when he was told about Mr Hughes' death.
22. The Ombudsman's initial report was issued in November 2017 with a recommendation that a Segregation Review Board should have been held for Mr Hughes. However, HMP Birmingham and the national policy lead on segregation in HM Prison and Probation Service (HMPPS) challenged the Ombudsman's finding. The Ombudsman acknowledges that Birmingham complied with the segregation policy in Mr Hughes' case. This initial report has been reissued with a recommendation that the segregation policy is amended, so that Segregation Review Boards are held after 72 hours, regardless of the initial reason for segregation.
23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
24. Mr Hughes' mother and father received copies of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Birmingham

25. HMP Birmingham is a local prison, and holds up to 1,450 men. It is managed by G4S Care and Justice Services. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour health services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services. The prison has two 15 bed healthcare wards, one for prisoners with physical health issues and one for those with mental health issues.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Birmingham was in February 2017. Inspectors reported that the care for prisoners at risk of self-harm was not sufficiently good, as caremaps were not updated to reflect progress and relevant staff, particularly mental health staff, did not attend case reviews regularly. Inspectors found that the regime in the Care and Separation Unit was often too limited, though the number of prisoners located there was very small and they stayed there for relatively short periods of time. Inspectors also found that primary healthcare services were reasonably good and both healthcare wards offered very good support to patients with complex physical and mental health needs. They reported that the provision of mental health continued to be good and had been enhanced by the addition of psychological interventions.

Independent Monitoring Board

27. 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 30 June 2016, the IMB reported that they continued to be concerned about the quality of ACCT documents and the timing of checks, especially during the night, though they noted that Safer Custody were addressing their concerns through regular reminders to staff, enhanced checks of ACCT documents and training of prison managers. The IMB reported that the Care and Separation Unit was well run with low numbers of prisoners. They found that good engagement between prisoners and staff yielded positive results. The IMB also reported that there continued to be a generally high level of prisoner satisfaction with healthcare provision, though staff sickness levels had impacted negatively on the healthcare regime.

Previous deaths at HMP Birmingham

28. Mr Hughes was the second person to take his own life at Birmingham since January 2016. We have made a previous recommendation about the need for ACCT procedures to be managed in line with national instructions.

Assessment, Care in Custody and Teamwork

29. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and 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.
30. 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 multidisciplinary 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.
31. 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, Management of prisoners at risk of harm, to self, to others and from others (Safer Custody).

Segregation

32. The segregation unit at Birmingham is known as the Care and Separation Unit (CSU) and comprises 13 cells.
33. Segregation units are used to keep prisoners apart from other prisoners. Prisoners may be held in segregation for a number of reasons, including awaiting an initial adjudication hearing (under Prison Rule 53(4)), and for the maintenance of good order and discipline (GOOD) (under Prison Rule 45) if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.
34. Prison Service Order (PSO) 1700 'Segregation' sets out the processes that prisons should follow when segregating prisoners, including measures to keep them safe. It recognises that segregation has a negative effect on the mental well-being of most prisoners, and that for some prisoners the effects can be serious.
35. The PSO provides that segregation must be authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.
36. The PSO also provides that an initial Segregation Review Board must be held within the first 72 hours of a prisoner being segregated under Prison Rule 45. The purpose of the review is to consider whether to continue the segregation, taking the prisoner's individual circumstances into account. The PSO says that the aim is to return a prisoner to normal location as soon as it is practicable to do so and that particular consideration must be given to the safeguarding of the

prisoner's mental health. The safety of the prisoner whilst in segregation is of paramount importance.

37. There is no similar provision in the PSO for prisoners segregated under Rule 53(4), but Prison Service Instruction (PSI) 47/2011 'Prison Discipline Procedures' provides that the initial adjudication hearing must be opened on the day after the prisoner has been charged with a disciplinary offence, unless that day is a Sunday or public holiday, in which case the initial hearing will be opened on the next working day. If the initial hearing is inconclusive, but it is considered that the prisoner still needs to be segregated pending a further hearing, segregation must then be authorised under Prison Rule 45.

New psychoactive substances (NPS)

38. New psychoactive substances (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.
39. 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.
40. HM Prison and Probation Service (HMPPS) 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 HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

41. On 17 September 2015, Mr Craig Hughes was remanded to HMP Hewell on suspicion of bringing a prohibited article into a prison. On 29 April 2016, he was sentenced to 32 months imprisonment and spent time at HMP Birmingham and HMP Oakwood. On 13 January 2017, Mr Hughes was released on licence. After threatening probation and approved premises staff, Mr Hughes was recalled to prison on 7 February and sent to Birmingham. While on licence, Mr Hughes had committed theft and he received an additional 28 day sentence as a result.
42. Mr Hughes was diagnosed with a borderline personality disorder in 2011 and schizophrenia in 2015. He was prescribed 200mg of quetiapine (antipsychotic medication) for the latter. He also had a history of drug abuse. During his time in custody, Mr Hughes committed numerous acts of self-harm, usually by cutting himself.
43. When Mr Hughes returned to Birmingham on 7 February, a nurse saw him for an initial health assessment. Mr Hughes confirmed what medication he was prescribed. He admitted to using drugs but declined a referral to the prison's integrated drug treatment service (IDTS).
44. On 8 February, a prison GP saw Mr Hughes, who said that he did not want an opioid prescription to treat his substance misuse. The GP prescribed diazepam to control Mr Hughes' withdrawal symptoms. Later that day, a Drug Alcohol Recovery Team (DART) worker saw Mr Hughes and explained the risks from new psychoactive substances (NPS). Mr Hughes signed a form to acknowledge that he had received this advice.
45. At 3.45pm on 8 February, Mr Hughes said he heard voices and that he wanted to take his life or self-harm. Staff began Prison Service suicide and self-harm monitoring (known as ACCT). During the ACCT assessment, Mr Hughes said that he had made many cutting and ligature attempts in the past year, so staff made a mental health referral.
46. Between 9 and 16 February, staff held four ACCT case reviews and assessed that Mr Hughes' risk of suicide and self-harm was low (on a scale of low, raised and high). Healthcare staff attended two of the reviews. Mr Hughes said that he felt paranoid and made superficial cuts to his arm on 13 February. A prison manager completed a caremap (designed to identify the main areas of concern and the actions required to reduce risk) and recorded that Mr Hughes had been referred to the mental health team and to a prison GP to address his mental health and medication issues respectively. On 23 February, a prison manager closed the ACCT because Mr Hughes' medication issues had been resolved.
47. On 10 February, a nurse examined Mr Hughes following the mental health referral. She noted that he appeared to be responding to unseen stimuli, was hearing voices and was talking to himself. She considered that Mr Hughes was mentally unwell so added him to her mental health caseload and referred him to the prison psychiatrist.
48. Later that day, a psychiatrist examined Mr Hughes and considered that he had a dual diagnosis of chronic psychosis, possibly schizophrenia, with substance

misuse problems. The psychiatrist admitted Mr Hughes to the mental health ward and increased his quetiapine dose to 300mg.

49. On 13 February, an occupational therapist reviewed Mr Hughes, who said that he was unhappy because he had expected to be released in three weeks but, as he had breached his licence, he would be in prison until 2018.
50. On the same day, an officer saw Mr Hughes for a Drug & Alcohol Recovery Team (DART) assessment. Mr Hughes admitted to recent use of cannabis, crack and NPS. The officer created a recovery plan, which included increasing Mr Hughes' awareness of the impact of drugs and for him to abstain from drugs while in custody.
51. On 28 February, the psychiatrist planned to discharge Mr Hughes from the healthcare unit as he was managing his voices and had been compliant with his medication. Mr Hughes told the psychiatrist that he should not be discharged, though he did not explain why. On 10 March, Mr Hughes was moved from the healthcare unit to C wing.
52. On 15 March, a nurse reviewed Mr Hughes' mental health and found that he was jovial with no signs of distress. Mr Hughes said that he was happy with his current medication and had no concerns about his mental state. The nurse planned a further review on 29 March.
53. On 29 March, a nurse reviewed Mr Hughes' mental health, who said that his audio hallucinations had reduced and that he could concentrate well. He denied any current thoughts of self-harm and denied any use of illicit substances. The nurse planned a further review on 26 April.
54. During the evening of 25 April, Mr Hughes cut his arm, as he had not been given his quetiapine medication. Staff placed Mr Hughes on an ACCT and a nurse ensured he understood when he was able to receive his medication.
55. On 26 April, a nurse saw Mr Hughes for his scheduled mental health review. Mr Hughes said that he had cut himself as he had not received his medication, which had been effective in lessening the voices he heard. The nurse did not find any evidence of acute mental illness so planned a further review on 14 May, though there is no record that this review took place.
56. Between 26 April and 2 May, staff held three ACCT case reviews and assessed that Mr Hughes' risk of suicide and self-harm was low. Mr Hughes reiterated that he had cut himself because he did not receive his medication. Healthcare staff did not attend any of the ACCT reviews. A prison manager did not complete a caremap for Mr Hughes and recorded on the first case review log that an assessor was "unable to complete assessment interview". A Safer Custody administrator attempted to complete a second assessment on 28 April though Mr Hughes refused to attend.
57. A prison manager closed the ACCT on 2 May as Mr Hughes had received his medication. There was no record that a member of staff had held a post-closure interview with Mr Hughes.

58. On 4 May, a nurse suspected that Mr Hughes was under the influence of an illicit substance, after he became unresponsive in his cell. She took his basic clinical observations and gave him naloxone (used to treat opioid overdoses). Mr Hughes quickly recovered. There was no record that the nurse referred Mr Hughes to the substance misuse team.
59. On three separate occasions between 12 May and 1 June, Mr Hughes pushed an officer, threatened to throw faeces at and assault another, and assaulted another prisoner.
60. On 5 June, Mr Hughes asked a nurse to see someone from the mental health team sooner than his next appointment, which had been scheduled for 14 June. The following day, a nurse saw Mr Hughes for an urgent mental health review. She noted that he appeared to be under the influence of an illicit substance, though Mr Hughes denied this. Mr Hughes said that he had contemplated self-harm the night before but that he felt better now and did not have any current thoughts of taking his life or self-harming. The nurse considered that his mental state was stable so planned a further review on 14 July. She told the investigator that she did not put Mr Hughes on an ACCT because he said that he no longer wanted to self-harm. There is no record that the nurse passed this information to prison staff or referred Mr Hughes to the substance misuse team.
61. At approximately 9.10am on 8 June, Mr Hughes punched an officer in the face after waiting to see a dentist. The officer and other officers restrained Mr Hughes and moved him to the Care and Separation Unit (CSU). During the restraint, Mr Hughes complained that he had hurt his left wrist. A prison manager placed Mr Hughes on report for the assault and, during an adjudication hearing held two days later, the matter was referred to the police. The police had not decided how to deal with the alleged assault before Mr Hughes' death.
62. Shortly after being moved to the CSU, prison officers searched Mr Hughes and found two white tablets in his tracksuit trousers. An officer placed Mr Hughes on report, though a separate adjudication hearing was not completed before Mr Hughes' death. He also passed the tablets to the security department, who tested them but were unable to confirm what they were.
63. At 10.45am that day, a nurse attempted to review Mr Hughes but he refused to engage with her. She recorded that he had smeared excrement on his observation panel. She then completed an Initial Segregation Health Screen and recorded that there were no clinical reasons to advise against segregating Mr Hughes. On the form, the nurse answered 'no' to the questions "Has the person self-harmed in this period of custody... or is the person currently taking any anti-psychotic medication?" and "Does the prisoner show signs of being acutely unwell?" When interviewed by the investigator, the nurse recognised that she had made a mistake in completing the form but said that she felt that Mr Hughes' mental health was not deteriorating.
64. At 12.25pm that day, Mr Hughes activated his cell bell and started banging on his cell door. When an officer answered, Mr Hughes said that he would kill an officer when he left the cell. The officer placed Mr Hughes on report for making threats against staff, though the hearing was not completed before Mr Hughes' death.

65. At 12.30pm, a senior prison manager reviewed the Initial Segregation Health Screen and confirmed that it was appropriate to segregate Mr Hughes.
66. At approximately 2.00pm, a nurse attempted to examine Mr Hughes' wrist but she was unable to do so as officers could not unlock him and she could not see through the observation panel as it was covered with excrement. She asked other healthcare staff to examine him once he had calmed down.
67. At 3.52pm that day, an officer recorded in Mr Hughes' prison record that he had been constantly kicking his cell door. Due to this and the verbal threats, CSU staff decided that three officers had to be present when unlocking Mr Hughes' cell.
68. At 5.18pm, a nurse examined Mr Hughes' wrist and noticed that it was very swollen. She asked a prison GP to examine it the following morning.
69. At 10.23am on 9 June, a prison GP examined Mr Hughes and noted that he had reduced movement in his wrist. The GP referred Mr Hughes to hospital for an X-ray. However, the prison was unable to arrange an escort to the hospital due to a lack of staff. The GP was not told about this. Mr Hughes did not have an X-ray before he died.
70. At 1.50pm, a nurse completed a second Initial Segregation Health Screen and recorded that there were no clinical reasons to advise against segregating Mr Hughes. On the form, the nurse answered 'no' to the questions "Has the person self-harmed in this period of custody... or is the person currently taking any anti-psychotic medication?" and "Does the prisoner show signs of being acutely unwell?" When interviewed by the investigator, the nurse said that she did not have the opportunity to check Mr Hughes' medical record before talking to him but that his presentation did not cause her any concerns.
71. At 2.00pm, a senior prison manager reviewed the Initial Segregation Health Screen and confirmed that it was appropriate to segregate Mr Hughes. He allowed Mr Hughes access to religious services, the library, education and exercise but did not allow access to a radio, television or in-cell hobbies. He planned a first segregation review board for 5.00pm on 11 June.
72. At 11.00am on 10 June, a nurse reviewed Mr Hughes, who made no reference to contemplating suicide or self-harm. The nurse completed a third Initial Segregation Health Screen and recorded that there were no clinical reasons to advise against segregating Mr Hughes. The nurse answered 'yes' to the question "Has the person self-harmed in this period of custody... or is the person currently taking any anti-psychotic medication?" and 'no' to "Does the prisoner show signs of being acutely unwell?".
73. At the same time, a senior prison manager reviewed the Initial Segregation Health Screen and confirmed it was appropriate to segregate Mr Hughes. He also demoted Mr Hughes to the basic level on the Incentive and Earned Privilege scheme on account of his poor behaviour and placed him on a Tackling Anti-Social Behaviour Scheme.
74. On two occasions that afternoon, Mr Hughes refused to return to his cell after staff let him out to make a telephone call and to collect a meal, respectively, as

he said that he wanted tobacco. Following the first incident, Mr Hughes returned to his cell after a five minute conversation with CSU officers and following the second, officers used control and restraint techniques to return him to his cell. At 4.30pm, a nurse checked on Mr Hughes and offered him pain relief for his wrist but he refused it.

75. Between 6.10pm and 9.00pm, officers made three entries in the CSU observation book describing Mr Hughes' behaviour. They recorded that he had threatened to assault a member of staff, had spat at an officer, had threatened to bite an officer's face and had blocked his observation hatch.

Morning of 11 June 2017

76. Officer A told the investigator that Mr Hughes had blocked his observation panel with faeces and toilet roll during the night. Officer A said that Mr Hughes cleaned the panel after activating his cell bell and asking for cleaning products. He believed that this happened at approximately 5.00am on 11 June, though records show that Mr Hughes first activated his cell bell at 6.18am.
77. Mr Hughes also activated his cell bell at 6.44am but there is no record of the reason or the staff response.
78. At 8.06am, Mr Hughes activated his cell bell, which Officer B answered. Officer B told the investigator that when he spoke to Mr Hughes, he threatened to assault an officer when they unlocked his cell door. Officer B said that he did not take any action and left Mr Hughes locked in his cell.
79. Officer C told the investigator that, at approximately 8.15am, Mr Hughes asked what regime he would receive that day. Officer C explained that his aggressive behaviour the day before meant he was unlikely to be given a shower or exercise. Officer C said Mr Hughes apologised for attacking officers.
80. At 9.37am, two nurses began to administer medication in the CSU, accompanied by a prison manager and Officer B. They visited three other cells before arriving at Mr Hughes' cell at 9.40am. The prison manager opened the observation panel and saw Mr Hughes hanging from a ligature, made from a shoelace, attached through small holes burnt into the plastic covering the window at the back of the cell. He and Officer B immediately entered the cell while one of the nurses called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) and the other nurse went to the CSU office to collect the emergency bag.
81. Officer B cut the ligature and Mr Hughes fell to the floor. The officers then lifted Mr Hughes onto the bed so the nurses had extra room to carry out cardiopulmonary resuscitation (CPR). The nurses started CPR, inserted an airway and attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.
82. On hearing the code blue, the control room immediately called an ambulance. The West Midlands Ambulance Service (WMAS) log confirmed that the first ambulance arrived at the prison at 9.41am, though the ambulance crew did not reach Mr Hughes until 9.49am, due to "tight security protocols". A witness statement from a paramedic for WMAS said that the ambulance waited in the

prison's holding vault for approximately six minutes for their mobile phones to be handed over. A second ambulance and a first responder vehicle arrived shortly afterwards.

83. The paramedics took over the resuscitation attempt and, at 10.16am, took Mr Hughes to Birmingham City Hospital, though the WMAS log said that it took 11 minutes to leave the prison due to "waiting for staff to open gates". The paramedic's witness statement said that the delay was due to staff needing the appropriate paperwork. Officers did not restrain Mr Hughes.
84. The ambulance arrived at the hospital at 10.32am. Hospital staff were unable to resuscitate Mr Hughes and a hospital doctor declared his death at 10.35am.

Contact with Mr Hughes' family

85. Following Mr Hughes' death, the prison appointed two prison managers as the prison's family liaison officers. At 12.25pm, one of the family liaison officers and the Director visited the home address of Mr Hughes' mother to break the news of his death and to offer their condolences and support.
86. The family liaison officers continued to support Mr Hughes' mother and other family members until his funeral. Mr Hughes' funeral was held on 30 June 2017 and the prison paid for the costs of the funeral in line with national instructions.

Support for prisoners and staff

87. After Mr Hughes' death, two prison managers debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Officer B, a member of the staff care team, also offered support.
88. The prison posted notices informing other prisoners of Mr Hughes' 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 Hughes' death.

Post-mortem report

89. The post-mortem examination found the cause of death was hanging, though the absence of facial congestion and conjunctiva haemorrhage (bleeding in the eye) suggests that death may have been a result of a vasovagal episode (when the part of the nervous system that regulates heart rate and blood pressure malfunctions) rather than asphyxia (a condition arising when the body is deprived of oxygen).
90. A toxicology report found a therapeutic level of quetiapine and paracetamol in Mr Hughes' blood. There was no evidence of any commonly abused drugs, including benzodiazepines, cannabinoids or cocaine metabolite.

Findings

Assessment of Mr Hughes' risk of suicide and self-harm

91. Prison Service Instruction (PSI) 64/2011 'Safer Custody' sets out the processes that all staff should follow when they receive information that a prisoner poses a risk to themselves or to others. This includes that staff who receive information that may indicate a risk of suicide or self-harm must open an ACCT.
92. PSI 64/2011 also sets out the processes that should be followed when an ACCT is opened. This includes that an ACCT assessment must take place within 24 hours and that if the prisoner refuses to be involved, the ACCT assessor must complete it based on all available information; that healthcare staff must attend the first ACCT case review and subsequent reviews should be multidisciplinary where possible; and that the case manager must complete a caremap with actions aimed at reducing the risk of suicide and self-harm. It also includes that staff must record meaningful conversations with prisoners in the ACCT observation record and that a post-closure interview should be held within seven days of an ACCT being closed.
93. On 6 June, a nurse examined Mr Hughes, who said that he contemplated self-harming the previous night. Despite this statement, the nurse considered that she did not need to open an ACCT as he denied any current thoughts of suicide or self-harm and she felt he was stable mentally.
94. In our Learning Lessons thematic 'Risk factors in self-inflicted deaths in prisons', published in April 2014, we identified the three prevalent factors in self-inflicted deaths were mental health issues, a history of self-harm or suicide attempts and substance misuse. Mr Hughes displayed all these factors and we consider that the nurse should have treated his contemplation of self-harm more seriously than from prisoners who did not display these factors.
95. In relation to the ACCT opened in April, we are concerned that two ACCT assessors were unable to complete assessments with Mr Hughes and that there was no evidence that they completed assessments based on the available information.
96. We are concerned that healthcare staff did not attend any of Mr Hughes' ACCT reviews, despite access to medication being the cause of his self-harm. We are also concerned that during interviews with healthcare staff, only three nurses said that they had attended ACCT reviews.
97. Furthermore, we are concerned that the prison manager did not create any caremap actions to resolve the issues with Mr Hughes' medication. We consider this placed Mr Hughes at further risk of self-harm and could have been easily resolved.
98. We are concerned about the quality of entries in Mr Hughes' ACCT observation record. They included "lying on back awake" and "unlocked to go and get dinner", which do not appropriately assess Mr Hughes' progress and well-being.

99. We are also concerned that no post-closure interview was held with Mr Hughes, despite a prison manager having closed the ACCT on 2 May. This meant there was little consideration of how Mr Hughes had progressed since the ACCT had been closed.

100. We make the following recommendation:

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

- **Having a clear understanding of their responsibility to share information about a prisoner's risk of suicide and self-harm and start ACCT procedures when appropriate.**
- **Assessing a prisoner within 24 hours of the ACCT being opened. The assessor should complete the assessment based on all available information if a prisoner has refused to engage in the assessment.**
- **Setting ACCT caremap actions which are specific, meaningful and aimed at reducing prisoners' risks to themselves.**
- **Completing ACCT ongoing records fully and accurately, including details of conversations and interactions with prisoners. Purely observational entries should be kept to a minimum.**
- **Ensuring post-closure reviews take place at the proper time and take into consideration events since the closure of the ACCT.**

Segregation

101. PSO 1700 requires healthcare staff to complete an Initial Segregation Health Screen for all segregated prisoners. When nurses completed Initial Segregation Health Screens for Mr Hughes, on 8 and 9 June respectively, they failed to note that he had recently self-harmed and was taking antipsychotic medication.

102. When interviewed, one of the nurses recognised that she had made a mistake in completing the form but felt that her overall decision was correct. The other nurse explained that officers asked her to complete Mr Hughes' health screen while in the CSU completing other tasks and that this prevented her from checking his medical record. While she did not know about Mr Hughes' history of self-harm and prescribed medication, she felt that his presentation did not raise any concerns.

103. We are concerned that the nurses did not feel that accurately recording the information about Mr Hughes was a serious matter as we note, in his interview, that a prison manager said that it would have made him consider whether the healthcare unit was more suitable for him. He also said that if Mr Hughes was kept in the CSU, it would have increased the level of attention given to him. We consider these errors are significant and are troubled that neither nurse appeared to acknowledge or understand the implications of such basic mistakes.

104. In our Learning Lessons bulletin 'Segregation', published in June 2015, we identified the importance of prisoners being given some form of diverting activity when segregated. A prison manager allowed Mr Hughes access to religious services, the library, education and exercise but not to a radio, television or in-

cell hobbies. While legitimate security concerns may restrict provision, in normal circumstances we expect a radio to be offered.

105. Mr Hughes was taken to the CSU at approximately 9.10am on 8 June and was initially segregated under Prison Rule 53(4) as he was awaiting an adjudication. At 2.00pm on 9 June, following two adjourned adjudication hearings earlier that day, a prison manager decided to keep Mr Hughes in the CSU under Prison Rule 45 to maintain good order and discipline. The manager planned to hold an initial Segregation Review Board at 5.00pm on 11 June but Mr Hughes died before it took place.
106. We recognise that under Prison Service policy, set out in PSO 1700, the 72-hour time limit for holding an Initial Segregation Review Board only applies in the case of prisoners segregated under Rule 45. The manager's plan to hold the Review Board was, therefore, in line with Prison Service policy.
107. However, Mr Hughes had been segregated for over 72 hours before he was found hanging. While we accept that the prison had followed Prison Service policy correctly, we are concerned that there appears to be gap in the policy.
108. The PSO recognises that a prisoner's mental health is very likely to decline when they are kept in segregation. One of the purposes of the Initial Segregation Review Board is to discuss any concerns that may have come to light about how the prisoner is coping with segregation, in relation to their mental health and any self-harming behaviour, and to consider whether segregation continues to be appropriate. The PSO requires the Segregation Review Board to consider additional steps to safeguard the mental health of prisoners held in segregation. We take the view that a review of this kind is necessary within the first 72 hours of a prisoner's segregation, irrespective of which Prison Rule the prisoner is segregated under. If an Initial Segregation Review Board had taken place in Mr Hughes' case, it would have provided an opportunity to identify the apparent decline in his mental health.
109. We, therefore, make the following recommendation:

The Director and Head of Healthcare should ensure that staff manage prisoners held in the CSU in line with national guidelines, including that:

- **Initial Segregation Review Boards are held within the first 72 hours of a prisoner being placed in segregation, regardless of the initial reason for segregation.**
- **Initial Segregation Health Screens are completed accurately.**
- **Prisoners are provided with sufficient distraction activities, such as a radio or in-cell hobbies, unless there are overriding security concerns.**

Clinical care

110. The clinical reviewer considered that the physical and mental healthcare that Mr Hughes received at Birmingham was predominantly equivalent to that which he could have expected to receive in the community. However, we agree with the clinical reviewer that the prison's inability to escort Mr Hughes to hospital for an X-ray, when a prison GP and a nurse thought that he might have fractured his

wrist, was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Director and Head of Healthcare should ensure that where healthcare staff request an x-ray, the prisoner is escorted to hospital as soon as possible unless there are properly justified, exceptional and fully recorded reasons.

Substance misuse

111. Mr Hughes had a history of substance misuse. He initially refused any support from IDTS, though he did have limited engagement with the prison's DART team. DART workers made him aware of the risks of NPS and created a recovery plan to help him abstain from drugs. However, nurses suspected, on 4 May and 6 June respectively, that Mr Hughes was under the influence of illicit substances. While we are satisfied that they treated the physical effects of the substance misuse appropriately, we are concerned that neither nurse referred him to the substance misuse team. We consider that they missed an opportunity to try to address Mr Hughes' substance misuse and limit any impact that it may have had on his mental health. We make the following recommendation:

The Director and Head of Healthcare should ensure that prisoners who use illicit substances are referred to drug treatment services and warned about the dangers and risks to health.

Emergency response

112. PSI 03/2013 'Medical Emergency Response Codes' sets out the processes that staff should follow during medical emergencies. This includes that staff must prevent any unnecessary delay in escorting and discharging ambulances.
113. An ambulance paramedic explained that they were delayed entering and leaving Birmingham due to having to hand over mobile phones and prison staff awaiting completion of paperwork before leaving for the hospital. We consider that an overall delay of 17 minutes was unnecessary, avoidable and too long and that it prevented Mr Hughes from receiving advanced life support from paramedics and hospital staff. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, ensuring that there are no delays in directing or discharging ambulances.

Staff support

114. PSI 64/2011 and PSI 08/2010 'Post Incident Care' set out the actions that should be taken following a death in custody. This includes that a member of the care team should be invited to the hot debrief to provide one to one support to staff who have been involved in an incident.
115. Following Mr Hughes' death, Officer B, as a member of the care team, was asked to support the officers who were with Mr Hughes in hospital when he died.

This was despite Officer B having been one of the officers who discovered Mr Hughes hanging in his cell, which would have been a traumatic event.

116. While we appreciate that Mr Hughes died on a Sunday, which limited the availability of members of the care team, we consider it was inappropriate for Officer B to provide support to other members of staff when he was as likely to be in need of support himself. For future deaths in custody, we consider that a care team member who was not directly involved in the discovery of the prisoner or in the emergency response should provide support. We make the following recommendation:

The Director should ensure that after a death in custody all staff, including staff who are members of the care team, are offered appropriate and timely support from someone unconnected to the incident.

Family liaison

117. Following Mr Hughes' death, the Director and a family liaison officer promptly visited the home address of his mother to break the news of his death to her, his father and other members of his family. During this visit, Mr Hughes' father alleged that one of the visitors said that Mr Hughes had been fine on the morning of his death and had had time outside his cell. When they received evidence from the Coroner for Birmingham and Solihull, which included witness statements from a prison manager and Officer B, Mr Hughes' father believed that they had given inaccurate information, as Mr Hughes had not been well behaved or allowed time outside his cell that morning.
118. While we cannot be sure what the Director or family liaison officer said to Mr Hughes' family, we remind them of the need to provide accurate information when informing a family about a death in custody.

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