

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Hunter a prisoner at HMP Forest Bank on 15 February 2016

A report by the Prisons and Probation Ombudsman

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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 James Hunter died at HMP Forest Bank on 15 February 2016, having taken an overdose of prescribed medication. He was 36 years old. We offer our condolences to Mr Hunter's family and friends.

Mr Hunter had told staff in the early hours of 15 February that he had overdosed on prescribed medication. Despite his clinical observations being abnormal, staff left him in his cell. Nobody considered moving him to the healthcare centre for further clinical observation, his cell was not properly searched to establish if he had any other medication and nobody contacted the national poisons information service for advice. Although suicide and self-harm prevention measures were started, the correct procedures were not followed.

The clinical reviewer concluded the standard of care Mr Hunter received was not equivalent to that which he could have expected to receive in the community. If Mr Hunter had been managed appropriately when he disclosed he had overdosed, the outcome may have been different.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

February 2018

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Summary

Events

1. On 7 November 2015, Mr James Hunter was remanded to custody at HMP Forest Bank charged with sexual offences against children. He had a history of depression and alcohol misuse and, in 2014, he had reported suicidal thoughts.
2. In December 2015, he was seen by a mental health nurse, having told staff he felt depressed and anxious. In January 2016, Mr Hunter submitted a number of complaints which alleged he was being victimised by another prisoner.
3. In the early hours of 15 February 2016, Mr Hunter told staff he had overdosed on prescribed medication. His clinical observations were not identified as abnormal and, he was left in his cell, with his elderly cell mate. Prison Service suicide and self-harm prevention measures (ACCT) were started.
4. At 7.10am, a prison officer found Mr Hunter unresponsive sitting on the toilet. Resuscitation was not attempted as there were clear signs he had died. Paramedics arrived and confirmed Mr Hunter's death at 7.41am.

Findings

5. When Mr Hunter was seen by a mental health nurse in December 2015 she did not complete a full assessment of his needs and there was no follow-up.
6. Staff responded to his complaints of victimisation but did not open a formal investigation which would have been in line with Forest Bank's violence reduction policy.
7. When Mr Hunter disclosed that he had taken an overdose, staff failed to consider moving him to the healthcare unit so he could be clinically observed overnight. Staff also failed to conduct a search of Mr Hunter's cell for any remaining medication. A nurse recorded Mr Hunter's clinical observations as satisfactory, when they were not and did not seek advice on how to manage an overdose of antidepressants. Although an ACCT was opened, staff failed to complete the immediate action plan.
8. The clinical response to Mr Hunter's disclosure that he had overdosed was not equivalent to that which he could have expected to receive in the community.
9. The emergency response was not in line with national guidance. The officer who found Mr Hunter correctly radioed an emergency code, and nurses quickly responded with emergency equipment. However, there was a 20-minute delay before calling an ambulance.

Recommendations

- The Director should commission an investigation under the terms of PSI 06/2010 & AI 05/2010, Conduct and Discipline, into the decision by an operational manager not to move Mr Hunter to healthcare, not to complete a thorough cell search and the failure to complete an immediate ACCT action plan.
- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:
 - All staff should have adequate ACCT training and refresher training.
 - All staff should take the possible side effects of medication and other substances into account when assessing risk of suicide and self-harm.
 - Staff should set actions on the immediate action plan and caremap that are specific, meaningful and tailored to the individual to reduce their risk.
- The Director should review the effectiveness of HMP Forest Bank's violence reduction policy and its delivery, specifically ensuring:
 - The effective identification and management of victims and alleged perpetrators.
 - Effective support and protection for apparent victims with meaningful objectives and long-term solutions, which address their individual situations.
 - The risk of suicide or self-harm to victims of bullying and intimidation is considered.
- The Head of Healthcare should review the recording system for prescriptions to ensure there are no discrepancies between electronic and paper records, and ensure healthcare staff accurately update medical records.
- The Head of Healthcare should ensure mental health assessments take into account all relevant information, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
11. The investigator visited Forest Bank on 17 February 2016. She obtained copies of relevant extracts from Mr Hunter's prison and medical records. She visited the wing where Mr Hunter lived and spoke to prisoners and staff who knew him.
12. NHS England commissioned two clinical reviewers to review Mr Hunter's clinical care at the prison.
13. The investigator interviewed nine members of staff and five prisoners at Forest Bank in April, some jointly with the clinical reviewers. She also interviewed six staff by telephone.
14. We informed HM Coroner for Greater Manchester West District of the investigation, who gave us the cause of death. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Hunter's mother to explain the investigation. Mr Hunter's mother said he had had a number of difficulties with his cell mates and other prisoners while at Forest Bank, and wanted to know if he had been bullied in the time leading up to his death.
16. Aspects of this report have already been disclosed, in line with our established practices.
17. Mr Hunter's family received a copy of the initial report. They did not highlight any factual inaccuracies within the report. They asked a number of questions which have been answered in separate correspondence.
18. The prison also received a copy of the report and identified a factual inaccuracy about the number of prisoners held at Forest Bank, which we have amended.

Background Information

HMP Forest Bank

19. HMP Forest Bank is a local prison in Salford, serving courts in the North West. It holds 1,364 remanded and sentenced men. The prison is managed by Sodexo Justice Services. Sodexo also provides primary health care services. There is a 20-bed inpatient unit with 24-hour nursing cover. Greater Manchester West Mental Health NHS Foundation Trust provides mental health in-reach services.

HM Inspectorate of Prisons

20. The most recent inspection of Forest Bank was in February 2016. Inspectors found that most prisoners said they felt unsafe, an increase since the last inspection in 2012, but comparable to similar prisons. They noted the prison had a proactive approach to improving safety, but formal case management was weak. The quality of suicide and self-harm assessment, care in custody and teamwork (ACCT) case management was too often inadequate and the quality of contact records mostly poor.
21. Inspectors considered the management of medicines was reasonably good, but identified the need for improved clinical and managerial supervision of healthcare staff. The Inspectorate found the provision of primary mental health services was poor, and the lack of access to psychological interventions for those with mild to moderate mental health issues posed a significant risk. The Inspectorate was critical that there were no lockable cupboards in prison cells for in-possession medications.

Independent Monitoring Board

22. 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 annual report, for the year to 31 October 2016, the Board noted that Forest Bank had a high number of prisoner assaults and violent conduct, and a 70% increase in healthcare complaints. The Board reiterated the concerns highlighted by HMIP. The Board noted Forest Bank had received national recognition for their violence reduction work.

Previous deaths at HMP Forest Bank

23. Before Mr Hunter's death, there had been two self-inflicted deaths at Forest Bank in the previous two years, the most recent in September 2015.
24. In our investigation into a natural causes death in January 2015, although the circumstances were different, we found failures in clinical care and that healthcare staff did not carry out clinical observations as instructed.

Assessment, Care in Custody and Teamwork (ACCT)

25. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to

reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

26. On 7 November 2015, Mr James Hunter was remanded to HMP Forest Bank, charged with sexual offences against children. This was his first time in prison. Mr Hunter's person escort record (PER), a document that accompanies all prisoners when they move between police stations, courts and prisons, noted he had had suicidal thoughts in 2014, but said he was okay and had no concerns.
27. An officer saw Mr Hunter when he arrived. Mr Hunter asked for vulnerable prisoner status, due to the nature of his alleged offences. An officer completed Mr Hunter's first night interview. He noted that Mr Hunter said he had no thoughts of self-harm, but made no specific reference about the comments of suicidal thoughts on the escort record. He completed a cell sharing risk assessment, noting that there was no reason why Mr Hunter could not share a cell, that he was a vulnerable prisoner due to the nature of his alleged offences, and that he had had a history of self-harm. There is no record whether the officer considered if Mr Hunter was at an increased risk of suicide or self-harm having been remanded to prison.
28. At an initial health screen, Mr Hunter told a mental health nurse that in 1996 he had been diagnosed with depression and prescribed antidepressants (citalopram). Mr Hunter said he last had suicidal thoughts in 2014, but had no current thoughts of suicide and self-harm. Mr Hunter told the nurse he did not want to be assessed by a mental health nurse. The nurse noted that Mr Hunter was asthmatic, had recently been drinking heavily and that his heart rate and blood pressure were high. The nurse referred him to a prison GP.
29. At 3.52pm, a prison GP assessed Mr Hunter who told him that he had last drunk alcohol two days previously. He noted Mr Hunter was anxious and had a slight tremor, but his heart rate had lowered. He noted Mr Hunter had experienced a 'minor' change in his life by being admitted to prison and did not consider he was at risk of suicide. He prescribed Mr Hunter's asthma and antidepressant medication and started Mr Hunter on an alcohol detoxification programme. He prescribed vitamins (thiamine) to ease withdrawal symptoms.
30. A healthcare assistant began an alcohol detoxification care plan for Mr Hunter, noting that he would be reviewed twice a day for one week to identify any increase in withdrawal symptoms. Over the following week, healthcare staff regularly checked Mr Hunter in line with his care plan. Reception officers placed Mr Hunter in a shared cell on Houseblock 2, one of the prison's vulnerable prisoner wings.
31. On 20 November, a nurse noted in Mr Hunter's medical record that he had asked to see a mental health nurse as he felt depressed and anxious. She referred him to the mental health team.
32. On 2 December, Mr Hunter did not collect his medication. A pharmacy technician noted in Mr Hunter's medical record that she was unable to establish the reason for his non-attendance from wing staff, but she did not record which medication he failed to collect.

33. On 3 December, a mental health nurse assessed Mr Hunter. Mr Hunter told her he felt he needed stronger medication, but she concluded that his 'problems related more to anxiety' and gave him an anxiety workbook. She noted that Mr Hunter had previously sought help for mental health issues from his GP and other mental health services, but she recorded no specific information. She noted that Mr Hunter wanted to discuss his offending behaviour and had asked if he would be eligible for the sex offender treatment programme. She recorded she would contact the offender management unit on his behalf, but there is no evidence she did.
34. Another prison GP examined Mr Hunter on 10 December, as he had complained about back pain and inflammation in his groin. The GP prescribed pain relief and antibiotics. On 22 December, Mr Hunter was given a hepatitis B immunisation injection. This was the last recorded time Mr Hunter had contact with a member of healthcare staff. Mr Hunter's medical records note a number of missed appointments for vaccinations and the sexual health clinic, with no apparent follow-up or explanation of the reasons why he did not attend.
35. Mr Hunter submitted a formal complaint form (COMP1) on 4 January 2016, saying that Prisoner A had displayed hatred towards him and other prisoners on the wing. Mr Hunter wrote that he did not want to escalate the issue, but simply wanted Prisoner A behaviour to change.
36. On 6 January, Mr Hunter's personal officer recorded in his prison record that 'he [Mr Hunter] likes to moan a lot about his cell mates it seems to be that when he gets a new cell mate they (sic) don't get on this seems to be all the time he has no other issues this week.'
37. A senior officer responded to the complaint on 8 January. He encouraged Mr Hunter to report any further incidents but said that, as the details of his complaint had not been reported to staff at the time and, as there were no witnesses, no further action could be taken.
38. Mr Hunter submitted an appeal to this response (COMP1A) on 13 January, which described a further incident. Mr Hunter alleged Prisoner A had pushed him on 12 January, and told him not to communicate with his co-defendant. Mr Hunter submitted a further letter on 17 January, and included a list of incidents dated between 9 December and 13 January. He asked to be moved to a different landing. A prison manager responded on 20 January. He noted that he had spoken to Mr Hunter and Prisoner A (who claimed Mr Hunter was the antagonist), that staff on the wing did not witness the incident, but that Mr Hunter would be moved to a different wing, when the wing functions changed and more vulnerable prisoner spaces were created. Mr Hunter was encouraged to report any further incidents to wing staff immediately.
39. On 26 January, an officer noted in Mr Hunter's prison record that he had warned him about spreading rumours about his co-defendant and that his behaviour was unacceptable. Mr Hunter submitted a letter the same day, addressed to the wing manager, in which he said that he had been accused of bullying his co-defendant, that he felt victimised and that the officer did not have enough information about his previous complaints to challenge him. He asked for his issues to be investigated, and said that he was considering legal action against Prisoner A.

40. On 1 February, an officer recorded on Mr Hunter's prison record that there continued to be issues between Mr Hunter and Prisoner A, that both prisoners had been spoken to and a decision had been made to move Mr Hunter to a different wing when space was available.
41. A prison manager responded to Mr Hunter's COMP1A and letters on 3 February. He said the senior officers had discussed his allegations, had spoken to Mr Hunter and Prisoner A on several occasions but there was no evidence to support Mr Hunter's claims. He reiterated that it was in the interests of both prisoners to live on separate wings and Mr Hunter would be moved when the residential changes were made later in the month.
42. The next day, an officer recorded in Mr Hunter's prison record 'still working in workshop 2 he [Mr Hunter] seems to still have a problem with people on the wing he can some times be a drain on staff when he keeps getting a new cell mate'. Mr Hunter was not moved before he died and this was the last entry on his prison record.
43. On 11 February, a pharmacy technician recorded that Mr Hunter did not collect his medication, but did not specify which medication. A healthcare manager told the investigator that Mr Hunter collected a box of 28 citalopram tablets on 13 January and 4 February, which was recorded on the prescription chart.

Monday 15 February

44. Closed Circuit Television (CCTV) shows that Mr Hunter was locked in his cell at around 5pm on Sunday evening. At 1.16am, Mr Hunter's cell mate pressed the cell bell. He told the investigator that Mr Hunter had had a number of 'seizures'. The night patrol operational support officer, responded over the intercom and he told her that Mr Hunter was 'dizzy'. The night manager was in the wing office completing his routine checks. He left during the night patrol operational support officer conversation with the cell mate, as he was due to co-ordinate a fire drill on another wing.
45. CCTV shows the night patrol operational support officer went to Mr Hunter's cell at 1.19am. She talked through the observation panel for two minutes to the cell mate and Mr Hunter before returning to the wing office. She told the investigator Mr Hunter was lying on the top bunk and it was difficult to communicate with him, but the cell mate relayed that Mr Hunter needed the toilet but could not get to it. She said she was concerned as Mr Hunter's breathing was 'heavy', so she returned to the wing office and called a nurse. He wrote one entry in Mr Hunter's medical records at 1.22am (which included information from his examination after 1.34am so may have been completed later). He recorded that Mr Hunter 'looked unwell through the viewing point' and had taken a deliberate overdose of 80 antidepressant tablets 'at least 6 hours ago'.
46. At 1.30am, the night patrol operational support officer went back to Mr Hunter's cell to check on him. She was concerned whether he was conscious, as he was lying on his bed with his eyes closed. She described Mr Hunter as struggling for breath and that his breathing was 'raspy'. At 1.33am, the operational manager returned to the wing to open the cell door along with the assistant night manager, and patrol two officers. The nurse arrived at the same time.

47. Mr Hunter said he still felt dizzy and was assisted from the top bunk. The nurse examined him. Mr Hunter told the nurse and prison staff that he had taken between 60-80 antidepressant tablets (citalopram). The nurse examined Mr Hunter and recorded that his temperature was 36.4C (a normal reading), his pulse was 117bpm (a high reading - a rapid heart rate known as tachycardia) and his respiratory rate was 12 (a low reading). He recorded that all three readings were satisfactory, despite Mr Hunter's pulse and respiratory rates being outside the normal range. He noted that the prison GP should review him later.
48. At 1.48am, Mr Hunter's cell was locked without it being searched. The night patrol operational support officer checked on Mr Hunter at 1.54am. The night manager returned to the cell a few minutes later and removed Mr Harrington's medication which had been sitting on the table (paracetamol and antacid), but again nobody searched the cell. He told the investigator that the nurse had confirmed Mr Hunter had not collected his medication, and he felt reassured there would be no other medication in the cell.
49. Mr Hunter's mattress was placed on the floor for safety as he said he still felt dizzy, in case he needed to get up for the toilet again; staff did not feel it was fair to ask his elderly cell mate to move to the top bunk. In interview, the night patrol operational support officer described Mr Hunter as looking 'dizzy and clammy'. The night manager said Mr Hunter's movements and the noises he was making were 'a bit exaggerated' and he was unsure whether or not he was genuinely unwell.
50. At 2.00am, the night patrol operational support officer began suicide and self-harm prevention procedures, known as ACCT. She completed the ACCT "concern and keep safe" form and recorded that 'Mr Hunter claimed he had taken 80 tablets but said he did not know why he had taken them'. As is standard practice at Forest Bank when an ACCT is opened during the night, observation of Mr Hunter was completed twice an hour. The immediate action plan, which should have been completed within one hour by the night manager, was not done.
51. CCTV confirms that the night patrol operational support officer checked Mr Hunter regularly. At 2.26am, 2.51am, 3.18am and 3.47am she recorded he was on his mattress and appeared asleep. At 4.15am she observed Mr Hunter getting up off the floor and at 4.44am he was sitting on his bed talking to his cell mate. She completed a routine check of prisoners at 5.04am and recorded Mr Hunter was sitting on his bed. The next recorded observations at 5.25am 5.46am and 6.00am, stated he was on his bed talking to his cell mate. She told the investigator that the nurse contacted her by telephone just before the end of the night shift and she told him she had no further concerns about Mr Hunter. There is no record of this conversation on the ACCT or medical record.
52. At 6.20am, an officer arrived on the wing. He unlocked the servery workers to prepare breakfast. An officer arrived on the wing to start his day shift around 6.30am, and started a routine check of prisoners. CCTV shows the officer arrived at Mr Hunter's cell at 6.35am and looked through the observation panel. He noted in the ACCT that Mr Hunter was 'sat on toilet movement noted'. He told the investigator that when he looked through the observation panel, his cell

mate was sitting facing Mr Hunter, and replied that Mr Hunter had been like that 'all night'. He told him they would soon be unlocked for breakfast. The officer told the investigator the cell mate did not seem concerned and, because he had seen Mr Hunter's leg move, assumed he was just using the toilet.

53. An officer arrived on the houseblock around 6.45am (his shift started at 7.00am) and stayed in the office, when two officers started to unlock the cells for breakfast. He recorded in the ACCT at 7.00am 'sat on chair no toilet' [although the word toilet looks to have been overwritten with the word issues]. CCTV confirms he did not go to Mr Hunter's cell.
54. CCTV shows the officer started the morning roll check at 7.05am and arrived at Mr Hunter's cell at 7.07am. He told the investigator that when he unlocked the door, he saw Mr Hunter on the toilet, apologised and shut the door. He returned at 7.10am, because he heard his cell mate call him. He opened the door, shouted for an officer and immediately radioed a 'code blue' medical emergency, (indicating a life threatening incident involving breathing difficulties). The control room responded to the radio message and instructed prison staff and nurses to attend, but did not immediately request an ambulance. His cell mate was taken out of the cell.
55. A minute later, two nurses arrived at the cell. They examined Mr Hunter and noted that there were no signs of life. A nurse told the investigator that Mr Hunter was cold, had some stiffness in his limbs and his arm was purple where blood had pooled. As it was clear that Mr Hunter had died they did not try to resuscitate him.
56. An operational support officer in the control room logged that he requested an ambulance at 7.25am. North West Ambulance Service records show that they received the request for an ambulance at 7.30am. In interview, he told the investigator that he and his colleague had never managed an emergency and overlooked calling an ambulance.
57. Paramedics arrived at Mr Hunter's cell at 7.41am, 31 minutes after Mr Hunter was found unresponsive. The paramedics assessed Mr Hunter and recorded that he was dead. It was his 36th birthday.
58. Two prisoners, friends of Mr Hunter, told the investigator they were unaware of any bullying issues, although they said some prisoners did not like him. They were aware Prisoner A, had allegedly spread rumours about Mr Hunter's offending but said Mr Hunter was his normal self the evening before he died and seemed 'fine'. One reflected Mr Hunter had said he could not cope in prison, but said he had not thought at any time that he was suicidal.

Contact with Mr Hunter's family

59. The prison appointed two members of staff as family liaison officers. They arrived at Mr Hunter's mother's house at 9.30am to break the news of his death, but there was no answer. The family liaison officers made efforts to locate Mr Hunter's mother, but were unsuccessful so returned to Forest Bank. Later that morning at 10.55am, Mr Hunter's mother answered the telephone and she was

informed of her son's death. The prison contributed towards the cost of the funeral in line with national instructions.

Support for prisoners and staff

60. A senior manager debriefed the prison staff involved in the emergency response and offered her support and that of the staff care team. Another manager held a further debrief on 10 March.
61. The prison posted notices informing prisoners of Mr Hunter's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Hunter's death.

Post-mortem report

62. A pathologist concluded that Mr Hunter died from citalopram toxicity (overdose). Mr Hunter's blood concentration level was 19.6mg (fatal cases of citalopram toxicity have been reported in cases of above 1.5mg). Although the contents of Mr Hunter's stomach suggested citalopram had recently been consumed, the pathologist was unable to establish exactly when before he died. No other illegal drugs or alcohol were detected.

Findings

Response to Mr Hunter's disclosure that he had taken an overdose

63. When prison staff and a nurse attended Mr Hunter's cell at 1.33am on 15 February, he told them that he had taken 60-80 antidepressant tablets earlier that evening. His cell mate had reported that Mr Hunter had suffered a number of 'seizures' and the night patrol operational support officer had expressed concern that he was having difficulty breathing.
64. No consideration was given to moving Mr Hunter to the observation ward to enable further clinical observations during the night (this four-bed ward within the healthcare unit was empty at the time). The healthcare manager told the investigator that this option is regularly used if there are concerns about a prisoner's health and there is uncertainty as to whether a hospital transfer is necessary. He said he was guided by the nurses clinical assessment that there were no immediate concerns.
65. Despite Mr Hunter disclosing he had overdosed on his prescribed medication, staff failed to conduct a search of Mr Hunter's cell to establish if there was any evidence to corroborate his account of what he had taken or if there was any medication left. The night manager had a cursory look around the cell and, a short while later, returned and removed Mr Hunter's cell mate's medication. The senior prison manager responsible for security, operations and safer custody, told the investigator that there is nothing written in the night protocols specifically about cell searching, but with the number of staff present they would have had the resources to search Mr Hunter's cell. She reflected that a visual check was probably common practice in such circumstances. The night manager accepted in hindsight that he should have conducted a thorough cell search.
66. After Mr Hunter's death, police searched Mr Hunter's cell as a matter of routine. They found a bag full of Mr Hunter's medication, including a 28 pack of citalopram with only three tablets remaining. This bag was in clear view, under Mr Hunter's bed. The post-mortem was unable to determine when Mr Hunter had taken his medication, but it is possible Mr Hunter still had medication in his cell after staff had attended in the early hours of 15 February.
67. Forest Bank had no protocol in place for prisoners suspected of taking an overdose, other than for paracetamol. The decision on the management of Mr Hunter was based solely on the nurse's clinical judgement. Since Mr Hunter's death, a detailed protocol has been established. For this reason, we do not make a recommendation.

ACCT management

68. We are satisfied that there was no indication that Mr Hunter was at increased risk of suicide and self-harm prior to his disclosure about his overdose. The investigator did not identify any reason why Mr Hunter's birthday would have been a trigger for suicide or self-harm.

69. Prison Service Instruction (PSI) 64/2011 - *Safer Custody*, sets out the procedures that should be followed when a prisoner is subject to ACCT monitoring. Within one hour of an ACCT being opened, a prison manager should complete an immediate action plan. The purpose of the immediate action plan is to consider and record the most appropriate environment and regime to support the person at risk. Relevant areas to be considered include location (including referral to healthcare), frequency of staff support and medical intervention.
70. The night patrol operational support officer began ACCT procedures at 2.00am on 15 February. The night manager should have completed an immediate action plan within an hour, but did not do so. He told the investigator that he (or his assistant night manager) would typically have completed the plan but accepted that the failure to complete an action plan was an oversight on his part. We are concerned that this important part of the ACCT process was not carried out.
71. An officer recorded in Mr Hunter's ACCT that he had observed him sitting on the toilet at 7.00am, but CCTV footage shows he did not go to Mr Hunter's cell. Further, the officer altered an entry on the ACCT ongoing record, having altered 'sat on chair no toilet' to 'sat on chair no issues'.
72. A senior manager at Forest Bank conducted an internal investigation into events between 5.00am and 7.10am on 15 February. The officer told the senior manager that he thought he heard another officer shout to him that Mr Hunter was on the toilet, as an explanation for this entry, but accepted he did not conduct the check himself. The officer denied altering the ACCT, but said that he did not fully remember events. The officer has since resigned from the Prison Service and did not respond to requests to be interviewed for this investigation.

The Director should commission an investigation under the terms of PSI 06/2010 & AI 05/2010, Conduct and Discipline, into the decision by the night manager not to move Mr Hunter to healthcare, not to complete a thorough cell search and the failure to complete an immediate ACCT action plan.

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

- **All staff should have adequate ACCT training and refresher training.**
- **All staff should take the possible side effects of medication and other substances into account when assessing risk of suicide and self-harm.**
- **Staff should set actions on the immediate action plan and caremap that are specific, meaningful and tailored to the individual to reduce their risk.**

Violence reduction measures

73. A PPO publication in October 2011, *Violence reduction, bullying and safety*, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013 - 2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and responded to robustly.

74. Forest Bank has a violence reduction policy, issued in August 2015, which sets out the process for raising and investigating any identified or suspected acts of aggression, bullying, intimidation or violence. This policy states that a Minor Violence Incident Investigation Form (Annex C) should be completed by a senior officer after every violent or alleged incident and returned to the Safer Custody Manager within five days. Although Mr Hunter raised concerns on several occasions, there is no evidence anyone initiated formal violence reduction measures.
75. A senior manager responded on two occasions (20 January and 3 February) to complaint forms submitted by Mr Hunter. He concluded there was insufficient evidence to support Mr Hunter's claim of being intimidated and noted that he had spoken to both Mr Hunter and Prisoner A (the alleged bully), and that no member of staff on the wing had observed anything untoward. He stated that it was in the best interests of both prisoners to live on separate units. He told the investigator that he did not initiate formal violence reduction measures, as this would have been the responsibility of wing staff. He accepted that if the policy had been explicitly followed, violence reduction measures would have started immediately, but said 'common sense' should be applied when there is no evidence of an act of violence or specific intelligence from staff.
76. The senior manager told the investigator that moving a vulnerable prisoner to another wing was not easy due to the lack of spaces. Forest Bank were in the process of changing the role of some wings, to create additional vulnerable prisoner places. These spaces only became available on the day Mr Hunter died.
77. We consider that Forest Bank staff failed to initiate violence reduction measures in line with their own policy. We make the following recommendation:

The Director should review the effectiveness of HMP Forest Bank's violence reduction policy and its delivery, specifically ensuring:

- **The effective identification and management of victims and alleged perpetrators.**
- **Effective support and protection for apparent victims with meaningful objectives and long-term solutions, which address their individual situations.**
- **The risk of suicide or self-harm to victims of bullying and intimidation is considered.**

Clinical care

78. The clinical reviewers found that the care received by Mr Hunter was not equivalent to the care he could have expected to receive in the community. They found that in the community, Mr Hunter would have been referred to A&E for assessment and treatment following his disclosure that he had taken an overdose, and therefore the failure of prison staff to do so meant that Mr Hunter did not receive equivalent care.

Clinical observations on 15 February

79. When a nurse took Mr Hunter's clinical observations following his disclosure that he had taken an overdose, he recorded that they were satisfactory in spite of his pulse rate being elevated and his respiratory rate being at the lower end of normal. On the basis that he had no concerns about Mr Hunter's welfare, he was kept in his cell rather than being moved to the observation ward. The nurse also failed to contact Toxbase, a 24-hour national poisons information service, or the local accident and emergency department for advice.
80. Sodexo Justice Services suspended the nurse on 17 March 2016, and he was dismissed on 14 December.

In-possession medication

81. The Head of Healthcare told the investigator that staff completed random compliance checks on in-possession (IP) medication every 30 days. However, due to the number of prisoners at Forest Bank there was no guarantee every prisoner with IP medication would be checked. Mr Hunter's medication was prescribed monthly. The electronic medical record (SystemOne) was used in addition to paper prescription records and reminders were generated automatically. However, it was unclear when trying to reconcile the electronic and paper records how many tablets had been issued, and whether Mr Hunter had collected his medication (as the electronic medical record noted he had failed to collect some prescriptions).
82. The Head of Healthcare said that the electronic medical records can be confusing and unreliable as the prescription DNAs (did not attend) do not accurately reflect whether a prisoner has collected medication. She said the nurse should have checked the paper prescription chart. In his police interview, the nurse said he found the medical record notes were confusing, and he did not think Mr Hunter had collected his antidepressant medication as they were noted with DNAs. Prescription records available to the investigation are signed to say Mr Hunter collected his medication, but were also inaccurate regarding the number of tablets issued. Police confirmed with the prison pharmacist that 112 citalopram tablets had been issued to Mr Hunter during his time at Forest Bank.

The Head of Healthcare should review the recording system for prescriptions to ensure there are no discrepancies between electronic and paper records, and ensure healthcare staff accurately update medical records.

Mental health

83. Mr Hunter had a mental health assessment on 3 December. A nurse told the investigator that time for assessments was very limited, around fifteen minutes. She told the investigator that she did not have time to complete a full assessment, did not review the medical records and did not use a standard assessment tool to assess the extent of Mr Hunter's depression; she said she was not familiar with assessment tools. Contrary to NICE (National Institute for Care and Health Excellence) guidelines, Mr Hunter was not offered any psychological therapies to support him with his depression and he was discharged. Improving Access to

Psychological Therapies (IAPT) is not available at Forest Bank, but is a standard intervention for anxiety and depression in primary care in the community. We make the following recommendation:

The Head of Healthcare should ensure mental health assessments take into account all relevant information, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines.

Emergency response

84. PSI 3/2013 requires prisons to have a medical emergency response code protocol, which states how staff should communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used. Forest Bank's local emergency response codes protocol reflects national guidance.
85. An officer correctly radioed an emergency medical code at 7.10am, but an ambulance was not requested by the control room until 7.30am (control room records note the call was made at 7.25am). The two operational support officers in the control room were inexperienced and had never dealt with an emergency situation. They told the investigator they were not sufficiently trained and were unaware what to do when a medical emergency code was radioed.
86. Prison training records were provided, signed by both men, which showed this had been addressed during their induction training. A senior manager said that that following an internal investigation, both officers were given an improvement notice (a first formal warning) and further training.
87. While the delay in calling an ambulance would not have altered the outcome for Mr Hunter, as it is apparent that he had been dead for some time, in other emergencies any delay could be critical.
88. Forest Bank issued a Director's Instruction (No9) – Emergency Response Codes on 26 April 2016, reiterating the need for control room staff to request an ambulance immediately a medical emergency code is radioed, in line with national guidance. Given the prison has already taken steps to address this issue we do not make a recommendation.

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