

**Circumstances surrounding the death of a man following  
his release from HMP Nottingham  
in December 2007**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2008**

This is a report into the apparently self-inflicted death of a man in December 2007, two hours after his release from HMP Nottingham. In light of the circumstances (the man was seen throwing himself into the River Trent) and the fact that his death occurred so soon after he had regained his liberty, I have carried out this investigation under my discretionary power to consider those deaths following release from custody where issues are raised about the care provided by the Prison Service.

The man was aged 39. I offer my sincere sympathy to his brother for his sad loss.

The investigation was conducted by one of my senior investigators. I am grateful to Nottinghamshire Primary Care Trust for their appointment of a clinical reviewer, the Head of Healthcare at HMP Whatton, to examine the medical care that the man received while he was in custody.

My investigator received excellent support from the Safer Custody team at HMP Nottingham. I would also like to thank the Governor of Nottingham, for the time and resources that he and his staff gave throughout the investigation process.

The man had been born in Nottingham and spent his whole life in the area. He could not overcome his mental health problems and was unhappy with the treatment he received from community mental health services. His repeated offending occurred when he was under the influence of alcohol.

The man's death followed a short sentence, spent in two different prisons. It was his first experience of custody, and he spent much of that time supported and monitored under the Prison Service's ACCT procedures for those judged at risk of self-harm. The ACCT was closed four days before his death.

As part of this investigation, I examine the management of the man's level of risk to himself, including his mental health and dependence on alcohol. I also look at the measures taken before his release to ensure that he was effectively resettled into the community. While I cannot say that any of these matters contributed to his death, it is clear there are lessons to be learned.

I make eight recommendations and cite one example of good practice.

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## SUMMARY

The man was taken into the custody of HMP Leicester in November 2007. After two court appearances, he was transferred to HMP Nottingham. On reception at both prisons he described the mental health treatment he had received in the community and his problems with alcohol misuse.

On his way to Nottingham, the man said that he would cut his wrists. A self-harm warning form was raised and he was made subject to suicide prevention measures (Assessment, Care in Custody and Teamwork – ACCT) on the induction wing. Staff agreed to support him in contacting his brother and to help him get his medication sorted out. He was also to be checked regularly. The ACCT monitoring lasted two weeks and was then closed. During the final case review, the man told staff that he felt better and that his medication had been sorted out. In fact, he was yet to be prescribed the medication he received in the community.

The man was eventually referred to the mental health inreach team in Nottingham for the co-ordination of his care. He had previously been under the supervision of a local community mental health unit. Following an outburst on the wing on 23 November, his medical records were requested from the unit. They confirmed his medication. Nevertheless, the information was sought again by the inreach care co-ordinator when she first assessed him on 30 November. Again, she confirmed the man's medication with the unit. He had to see a psychiatrist to be re-prescribed his medication. He was listed for an appointment by the care co-ordinator on 30 November. He would not actually receive his prescription until 20 December 2007, four days before he was released.

In the meantime, he behaved bizarrely on the wing with occasional aggressive outbursts. He was seen regularly by his care co-ordinator, but she could not effectively plan his care until he was prescribed his medication. On 19 December, the man cut his wrists superficially in his cell. ACCT suicide prevention measures were started again. Following an assessment the next day, the assessor recommended that the monitoring continue because of his confused mental state. She did not think he was at risk of self harm but wanted him to be checked regularly by staff. She did not record her conclusion on the form, but told a member of staff her recommendation. A shift change meant that this recommendation was not passed on to the senior officer who chaired the initial case review. The suicide prevention measures were stopped the same day. Healthcare staff made no contribution to this case review. The man's care co-ordinator was on leave at the time, and there was no cover for her casework.

At about 9.30am on Christmas Eve, the man was released with £49.00 in his pocket. He was next seen about two hours later at the River Trent, nearly four miles away from the prison. He jumped over the barrier of Trent Bridge into the river. He was seen to force himself underneath the water several times. His body was discovered at 2.55pm by police.

In this report, I consider the suicide prevention procedures at Nottingham and the mental health treatment that the man received. I also examine the support available for prisoners who have problematic alcohol misuse but are not alcoholics.

## THE INVESTIGATION PROCESS

1. One of my investigators was appointed to lead the investigation into the circumstances of the man's death. One of her colleagues and fellow investigator visited HMP Nottingham on her behalf on 8 January 2008 to open the investigation. She met the Governor and representatives from the Prison Officers' Association and the Independent Monitoring Board. She was shown around the prison by the Safer Custody Manager and the appointed liaison point for the investigation. The investigator spoke with healthcare staff who knew the man and collected copies of his files. Upon her return, she fully briefed the lead investigator on her visit.
2. Nottinghamshire PCT originally appointed a healthcare manager at the prison to conduct the clinical review. I must thank them for responding to concern raised by my investigator about the independence of such an arrangement. As a result, the Head of Healthcare from another prison within the PCT's area was appointed to conduct the review.
3. The lead investigator issued notices inviting staff and prisoners to contact her with any information that they felt might be relevant to the investigation. There was no response to these notices. She conducted several interviews with staff throughout March, accompanied by the clinical reviewer.
4. I am grateful to Nottinghamshire police for sharing their findings with my investigator and giving her access to statements taken during the course of their own investigation.
5. The Senior Family Liaison Officer wrote to the man's brother (his next of kin) to invite him to contact my office and be involved in the investigation process. Further to the letter, she spoke to the man's brother who provided a valuable insight into his brother's life. The man's brother was concerned about the circumstances of the man's death. I hope that this report gives him a better understanding of what happened on 24 December 2007 and during the previous weeks.

## HMP NOTTINGHAM

6. HMP Nottingham is a busy local prison that serves the courts in the Nottinghamshire area. Her Majesty's Chief Inspector of Prisons last made an announced inspection in October 2007. At that time, she found "detoxification arrangements were basically safe". However, she recommended that more time should be made available for doctors' appointments with prisoners going through detoxification. (The man told staff he was a "binge drinker" but did not seek or receive help for his alcohol misuse while in prison. Later in this report I will more fully consider what resources there are for those at Nottingham who drink heavily on occasion rather than persistently, but are nonetheless reliant on alcohol to stabilise their mood.)
7. Nottingham opened a prefabricated healthcare building in June 2007. HM Chief Inspector found the new healthcare facility to be "excellent". She judged that "mental health inreach services were working well, with good relationships between the primary care team". However, she was concerned that the mental health teams did not use the available facilities to their full potential. She recommended that "prisoners with mental health and allied problems should have access to appropriate therapeutic services".
8. In a previous inspection, HM Chief Inspector had highlighted that information about prisoners at risk of suicide or self harm was not being effectively communicated between shifts. However, she found that this matter had been addressed by the time of her 2007 inspection. She recommended that a broader range of disciplines should be invited to attend case reviews to discuss at-risk prisoners. She suggested that such reviews should be consistently chaired by the same case manager. (The ACCT procedures for monitoring prisoners at risk of suicide or self-harm are considered in more detail in this report.)
9. Finally, HM Chief Inspector of Prisons recognised "reasonable resettlement provision", but felt there was scope for improvement particularly in relation to liaison with families.

## KEY EVENTS

10. The man appeared at the Magistrates' Court on Saturday 10 November 2007 in connection with six counts of assaulting a police officer. He had also breached the terms of his Anti-Social Behaviour Order (ASBO). After being held in police custody, he was remanded to HMP Leicester on Tuesday 13 November.
11. The nurse working on reception that day completed his first reception healthscreen. (A first reception healthscreen is an interview by healthcare staff that takes place when a prisoner arrives at prison. It should determine any physical or mental health conditions that require treatment, any substance misuse matters that need to be addressed and any risk that the prisoner may pose of harming himself or attempting suicide.) During the reception screening process, the nurse noticed that the man was "a bit angry and worked up" and assessed him as a high risk to share another cell due to his mental health problems. He told staff that he drank excessively every fortnight when he received his benefit payment. The man said that he had received psychiatric treatment in the community, including a spell at a local clinic. He told the nurse that he was taking Fluoxetine (a drug used to treat depression) and Olanzapine (an antipsychotic medication). He admitted that he had tried to harm himself years ago outside of prison, but said that he had no thoughts of harming himself at the time of the screen. He was located in a single cell and was referred for a mental health assessment.
12. Assessment, Care in Custody and Teamwork (or ACCT) is the system used in prisons to identify, support and monitor prisoners at risk of self-harm or suicide. The nurse did not open an ACCT document at this time.
13. At the same time as the first reception healthscreen, another nurse carried out the man's second reception healthscreen to assess his physical health and found no concerns. The nurse made an entry in the clinical record that the man felt "let down by the system". In particular, the man was dissatisfied with the treatment he had received for his mental health condition. He told the nurse that he drank whenever he could afford to, which was usually when he received his benefit payment.
14. On 13 November, the man appeared at the Magistrates' Court and was remanded back to Leicester. The next day, he was seen by the resettlement team at Leicester and by the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATS) team. (The CARATS team work with prisoners who have a substance misuse problem, including alcohol.) The man had told the nurse at reception that he drank excessively every fortnight and the CARATS team had agreed to assess him. An officer from the resettlement team spoke with the man and identified that he had outstanding Housing Benefit that he must claim in order to retain the tenancy on his flat.
15. The man made a further court appearance at the Magistrates' Court on 15 November. According to his Prisoner Escort Record (PER), he threatened to kill himself by cutting his wrists on his way back from court. (A PER is a

record of staff observations while accompanying a prisoner between two destinations, in this case between the court and the prison.) A member of the escort staff raised a self harm warning form and checked him every ten minutes. After this court appearance, the man was remanded to HMP Nottingham. The officer on duty signed the self harm form raised by the escort team to confirm the information had been passed on to the prison.

16. A nurse completed the first reception healthscreen. (A first reception healthscreen must be completed each time a prisoner goes to a new establishment.) Despite the man's threats earlier in the day, he told the nurse that he had no thoughts of self harm. He explained his history of receiving psychiatric treatment, as he had done on reception at Leicester. Again, he was referred for a mental health assessment following his healthscreen. The man said that he drank occasionally.
17. That evening, the man saw the prison's most regular doctor. The doctor sees all prisoners for a health check when they arrive at Nottingham. He found that the man had no thoughts of suicide.
18. After the man's reception healthscreen, the induction officer received him on the induction unit and located him in a shared cell. Despite the doctor's conclusions that he was not at risk of self harm, the officer raised a Concern and Keep Safe form, the first stage of the ACCT process. He recorded that he was concerned because of what the man had said earlier about killing himself. The officer recorded that the man told him he had mental health issues but that he would not kill himself. In line with ACCT procedure, he passed the Concern and Keep Safe form to his manager, the wing Senior Officer (SO), who completed the immediate action plan. The SO ensured that the man was in a shared cell so that he had company which he seemed happy about. She also required staff to check the man infrequently during the night shift. She offered him the chance to speak to a Listener or use the Samaritans telephone for extra support. (A Listener is a prisoner who has been trained by the Samaritans to support prisoners through periods of crisis.) He refused both offers because "he felt ok at present". The man told the SO that he was keen to speak to his brother but did not have his telephone number. The man said that he would write to him instead.
19. Every prisoner who arrives on the induction unit has a first night interview. The wing officer carried out the man's interview. The man told the officer that he had said he would kill himself only out of frustration with his solicitor and did not really mean it. He said that it was around six or seven years since he had last self-harmed.
20. On 16 November, the man was seen by the resettlement team. He completed a "Resettlement Unit Passport", which assessed his employment, financial and housing needs. He told the resettlement team that he was owed benefits that he wanted help to claim. He also wanted assistance to pay a fine that he had been given at court. The housing needs assessment is incomplete as the man had his own council flat and needed no assistance in securing accommodation. Following this meeting, a Welfare Rights and Benefits

Advisor in the resettlement team, wrote to Nottingham City Council on the man's behalf. She enclosed a housing benefit claim, with details of his benefits claim under the 52 week rule. (The 52 week rule entitles people, including remand prisoners, who are temporarily absent from home to continue to receive housing benefits for up to 52 weeks.)

21. The staff nurse was called to the wing three days later (19 November 2007). There were concerns about the man's erratic and aggressive behaviour on the wing. There is no entry about this on his wing sheet but the nurse recorded her visit in his clinical record. She found his clinical file in the pending tray of the healthcare centre, but it was not clear what the outstanding action was. She was unsure whether a mental health referral had already been made, but completed one just in case.
22. On 21 November, the nurse on duty was called to the wing because the man had complained about shortness of breath. When the nurse reached the cell, the man swore at her and went back to bed.
23. The man's mental health assessment took place later that same day. Registered Mental Health Nurse (RMN) was briefed about the man's "verbal hostility" towards officers and the bizarre behaviour that he had displayed. The man told the mental health nurse that he could not breathe and he thought that staff wanted him to die. He said that he had been "abandoned by statutory agencies in the past". The RMN recorded the following impression:

"... some mood disturbance, evidence of low mood or agitation justified restoration of antidepressant ... temporary move to single cell also recommended. No serious self-harm ideation could be elicited. Never really contemplated suicide because of relationship with one of his brothers."
24. The man was supposed to move to a single cell but was unhappy about it. He told an officer on the wing that he would "behave himself" if it meant that he could stay with his cellmate. In the event, the man did not move cells.
25. Healthcare staff were called to his cell again the following day. He was banging his head against the cell door while crying. He told the nurse that he felt desperate because he had received no medication for a week. The doctor prescribed Zopiclone, which is used to promote sleep. The nurse reviewed the man's ACCT document and increased his observations to two quality observations per day and two observations during the night. He also asked the mental health inreach administrative support staff to retrieve the man's community medical records from a local community mental health service.
26. The prison doctor completed a primary care referral to a registered mental health nurse (RMN) which was received on 23 November. He wrote that the man had a possible mental illness. He also suggested that the man might have been under the supervision of a community mental health service, and had been prescribed Olanzapine.

27. At Nottingham, any prisoner receiving treatment from a secondary mental health service is cared for by the inreach team. Therefore, the primary care team, including the prison doctor, do not prescribe medication for mental health conditions even when it is a continuation of medication received in the community. In order to be prescribed the medication that the man had received from the health centre, he had to be assessed by a psychiatrist who could then prescribe the medication.
28. A nurse contacted the the community mental health service to confirm that the man was prescribed a low dose of Fluoxetine and Olanzapine. The Community Psychiatric Nurse (CPN) confirmed that he would see the man the following Tuesday to carry out a full assessment. In fact, it was his colleague who took up the man's referral. In the meantime, another prison GP, prescribed a 10mg dose of Olanzapine for that night.
29. On 24 November, the man told the landing officer that he was not happy on the induction wing, because "it was not working out". He was recorded as:
- "... pressing his cell bell on numerous occasions today and appears angry and frustrated, depending on the answer that he receives. Upset also that a letter was returned to him from Royal Mail."
- Apparently the letter was returned because the address was incomplete.
30. That Tuesday (27 November), the man completed his induction period and was moved onto E wing. His ACCT document remained open and he was recorded as "calm and settled". There are well-recorded interactions in the ACCT ongoing record throughout this time. He told staff that he did not know why he was still on an ACCT because he no longer felt miserable.
31. The man appeared at the Magistrates' Court on 29 November and was re-remanded to Nottingham. His ACCT document remained open but the nurse who was on reception when he returned from court noted that she had no concerns about him. The man was due to have a secondary mental health assessment that day but could not attend due to his court appearance. It was postponed to the next day.
32. His ACCT document was closed on 30 November. The duty SO chaired the review, which the man attended along with another officer from the wing. No one from healthcare attended. The man made good eye contact throughout the meeting and it was noted that he had "settled quite well" on the wing. The man told staff that his medication had been sorted out, "which is helping a lot". In fact, he had not seen the psychiatrist and had not had a continuation of his medication. He was reminded that staff were there to support him if he needed them, and the ACCT document was closed. A post-closure interview was scheduled for 12 December 2007.
33. An occupational therapist employed by Nottingham Mental Health Trust as a care co-ordinator for the inreach team completed the man's secondary mental health assessment on 30 November following the prison's doctor's mental

health referral received on 23 November. She recorded that the man engaged willingly with the interview but was a “poor historian” (that is, he could not easily recall what treatment he had received in the past). She also completed the Health of the Nation Outcome Scale (or HoNOS). She told my investigator that she uses this assessment with all of her patients to determine what level of risk the prisoner poses to himself and to others. The assessment focuses on the current picture of a prisoner’s mental state and only the previous two weeks of records are used to inform the judgement. Following the man’s assessment, the occupational therapist concluded that he had previously been a risk to himself and others but was not currently a risk. The man denied any thoughts of self harm, although he did seem low in mood and said that he was having trouble sleeping.

34. Every Thursday, all members of the inreach team meet to discuss referrals. The occupational therapist identified that the man needed to be assessed by a psychiatrist in order for him to be prescribed medication in line with his care from the community mental health service. She was concerned that the “gap” in him receiving his medication might alter his mental state. She also felt that their “therapeutic relationship” might improve if he was settled on medication.
35. Despite a nurse’s contact the previous week, the occupational therapist was not aware that the man’s medication had been confirmed by the doctor from the community mental health service. She telephoned the doctor’s secretary who faxed through a letter, addressed to her, outlining the man’s treatment in the community. In the letter, the doctor confirmed that the man was being prescribed Olanzapine and the antidepressant Fluoxetine before he was remanded to custody. He went on to draw her attention to the man’s drinking habits:

“... he lives on his own and drinks especially binge drinking and when he drinks he has seven pints and gets drunk when he gets his weekly payments. He told me that he drinks mainly lager and Stella and does not drink whiskey or other strong stuff.”
36. In interview, the occupational therapist remembered receiving this letter. She said she was concerned about the man’s use of alcohol but did not make a referral then to the Alcohol Problems Advisory Service (APAS). She wanted the man to be settled on his medication before exploring other issues, including his alcohol misuse. Had she worked with him for longer, she would have referred him to APAS and thought he would have benefited from working with the service.
37. The man received two behaviour warnings while he was on E wing because he did not attend his workshop. On the same day as his meeting with the occupational therapist his behaviour deteriorated further. According to wing records, the man “became irate and difficult to manage”. Healthcare staff were called to assist. When they arrived, he was apologetic. The following day, the man had an angry exchange with his cellmate about cigarettes. Staff told him to calm down and that they would sort it out after lunch. He was moved to D wing later that day. The occupational therapist told my

investigator that she was aware of the man's bizarre behaviour on the wing from his previous ACCT record, clinical notes and wing history. However, he always presented as "settled" when she met with him. She said she would ask him about these episodes of aggressive behaviour but he was always vague in his explanations.

38. The occupational therapist thought that the man would have been assessed by a psychiatrist on the morning of 6 December. She purposely made an appointment in the afternoon because she thought she could discuss the psychiatric appointment with the man. The man did not see a psychiatrist that morning. During their appointment, the therapist drew up a nursing care plan for him. She identified the need for a multi-disciplinary approach to the man's care to "explore and counteract feelings of low mood/suicidal ideation and self-harm by discussing coping mechanisms". During interview, she told my investigator that the man was not having suicidal thoughts at the time she drew up the care plan. She said she would have opened an ACCT document if that was the case. Rather, she was concerned that his suicidal thoughts might return without the appropriate support from staff.
39. The next day, the occupational therapist saw the man for his follow-up mental health assessment. She thought he seemed "settled in mood". He said that he was tired of telling people how he was feeling. He described his frustration with community mental health services and became agitated. He was pleased that he had been referred to one of the psychiatrists who work once a week at Nottingham. The man had been a patient of the psychiatrist in the community. He told the therapist that he was worried about his upcoming court appearance but that he would keep himself busy to distract himself.
40. The staff nurse left a telephone message for the occupational therapist on 10 December, as she was concerned about the man's agitation and outstanding medication issue. She asked that someone from the inreach team visit him. The therapist contacted the wing to be told that the man was in work that morning. She was not working, so booked an appointment on 13 December.
41. As scheduled, on 12 December, the SO on duty held the ACCT post closure interview and found that "identified areas of concern have been resolved". The SO recorded that the man was now being looked after by the inreach team and was "settled on his medication". In fact, the man had not yet been prescribed his medication.
42. The man appeared at the Magistrates' Court for sentencing on 13 December. His brother was at court with him. (It was the last time he saw the man.) The court sentenced the man to 90 days imprisonment, and the period he had spent on remand was to be taken into consideration. His remaining sentence was calculated and the man was due to be released on Christmas Eve. On the man's return from court, the nurse in the reception area observed that the man seemed to have "no problems".
43. Due to his court appearance, the man missed his appointment with his occupational therapist on 13 December. He had an outburst on the wing the

following morning and healthcare staff were called. A nurse saw him in the treatment room. The man said that he was wound up by other prisoners but that he would try to ignore them in future. He denied any thoughts of self harm and said he would like to restart his medication. The nurse was concerned by the man's tearful appearance and contacted the inreach team for an emergency review. He also discussed this with a nurse prescriber, who agreed that the man needed Zopiclone to help him sleep.

44. A couple of hours later, the occupational therapist met the man who told her that he was still on remand. She told my investigator that not much could be done at this meeting because the man was still awaiting an appointment with a psychiatrist for his medication to be prescribed. The man told her that he felt "much better when ... on regular medication" and was pleased when she told him that he would be assessed by the psychiatrist the following week. Again, the man assured her that he had no thoughts of suicide or self harm. This was the last time that she saw him before she went on annual leave. She did not hand over the co-ordination of his care because there are not enough staff in the inreach team for formal cover arrangements.
45. On 19 December, the man pressed his cell bell. A wing officer went to his cell. He observed him cutting his wrists through the observation panel on the door. He immediately contacted the healthcare unit who attended as an emergency. The nurse on duty dressed the man's wounds. His ACCT was reopened. The next morning, the man picked at the cuts on his arm from the previous day. The man was taken to the nurse who dressed his wounds. The man told officers that he was struggling on the wing and cutting himself was a "cry for help". He was moved to a quieter area of the prison on F wing. Staff thought that the man would benefit from the peace during his last few days of custody.
46. The Suicide Prevention Co-ordinator made an entry in the man's ACCT ongoing record to say that an assessment interview had been scheduled for the afternoon of 20 December. He noticed that the man's previous ACCT document, closed on 30 November, had simply been reopened and entries continued. In line with ACCT policy, he insisted that an ACCT assessment take place. The then assistant psychologist at the prison conducted the interview. She is ACCT assessor trained, although she has no formal training in mental health. During the assessment interview the man told her that he "was adamant that he did not want to die". He said that he was looking forward to spending Christmas with his brother and returning to his flat. He had no plans to self-harm and said that he would like to stop drinking. The assistant psychologist did not complete the last question of the form. It is entitled, "agree what is to happen with the interviewee". She told my investigator that ordinarily she would complete that section with her findings from the interview and a recommendation as to whether the ACCT document should remain open. However, on this occasion, she said she verbally passed her thoughts on to the F wing senior officer on duty at the time. The SO handed over to another SO for the evening shift. In interview, the F wing SO did not recall the assistant psychologist making a recommendation that the ACCT remain open. He said he would have mentioned it to the evening SO if he had been aware of the recommendation.

47. The ACCT case review was held by SO on duty later that afternoon. The man was thought to be irritated by the review because he felt he was being asked to repeat himself. The man told the SO that he was looking forward to being released. He said that he had a flat to go to and no intention of self-harming. He said that he self-harmed in order to move wings because D wing was too noisy. He thought that F wing was better and told the officers that the situation was resolved. The man, the SO and an officer on duty (who also attended the review) agreed that the ACCT document should be closed.
48. Another psychiatrist assessed the man on 20 December on behalf of his community psychiatrist. During the assessment, the man said that he felt better before his parents died and could think more clearly then. He said that he “felt badly” after cutting himself, but had no further thoughts of suicide or deliberate self harm. The psychiatrist concluded that the man should be re-prescribed an antipsychotic and an antidepressant, the medication he had received in the community. The psychiatrist is not trained in the electronic medical information system (EMIS) in use at Nottingham, so made a written entry in the clinical record. He instructed the administrative staff to make an entry about his appointment and to confirm the date of the man’s release so that there could be an effective handover with the community mental health team. No such note was made.
49. The man’s discharge check list was completed the same day. According to resettlement procedure, staff should carry out a check 14 days prior to discharge and a further check two days before release. Due to the short time between the man’s sentencing on 13 December and his release date, there was not time to complete the 14 day check. Instead, the man was seen on 20 December and on the day of his release, Christmas Eve.
50. On 24 December, the man woke up and was told to pack his belongings ready for release. He was escorted from the wing to the reception area of the prison. He was seen by a nurse who gave him one week’s worth of his prescription to “tide him over” until he saw his doctor. The man was not registered at a community practice and the health centre would have continued the co-ordination of his care.
51. The SO working in the reception area on the morning of 24 December, was getting prisoners ready for release. In interview, he remembered that the man did not have a coat. One prisoner lent him a coat but it went missing before he left the reception area. The SO noted that the man received £49.00 on the day of his release, that is the £46.00 discharge grant and £3.00 that he had earned while in prison. He recalled that the man was reluctant to accept the money. He did not say why, but the SO suspected that he was scared that other prisoners would take the money from him. The SO gave the money to his colleague to pass on to the man after he had gone out of the prison. The man did eventually accept the money as he was leaving the prison. The SO told my investigator that he had no concerns that the man was at risk of suicide or self-harm. He said that if staff had been concerned they would have informed the mental health inreach team.

52. The man was released at 9.30am. The next time he was seen was about 11.45am that morning. An eyewitness was sitting on a bench overlooking the river near Trent Bridge, about four miles from the prison. Apparently, the man and his brother and mother often went for walks in this area. The eyewitness saw the man with his hands on top of the bridge, leaning over the wall looking at the water. There was no one else with him. The man jumped over the barrier. He fell into the river with his arms and legs outstretched.
53. Another eyewitness was a passenger in a car about to cross Trent Bridge at that time. He saw the man in the water and called the police on his mobile telephone. The second eyewitness then got out of the car and ran towards the man, shouting, "Don't do it". The man looked towards the eyewitness briefly but then started to take deep breaths, held his nose and forced himself under the water. After several attempts, the man finally stayed underwater and the eyewitness lost sight of him.
54. The police attended and discovered an envelope and letter addressed to the man and a packet of cigarettes by the edge of the river. The Nottinghamshire Underwater Search team were called to retrieve the body from the water. He was found at 2.55pm. The underwater search officer moved him to the river bank. The man had £49.35 cash and a box of safety matches in his pockets. A toxicology examination found that he had no alcohol in his system at the time of his death.

### **Family Liaison**

55. The man was not in custody when he died. Nonetheless, the governing Governor wrote to his brother to express his sincere condolences and those of his staff. The Governor also gave the details of his family liaison officer and invited the man's brother to contact him or the FLO if there was anything with which they could help. The offer for support was not taken up, but I am pleased that it was made despite there being no formal requirement. I consider this to have been very good practice.

## ISSUES

### Resettlement

56. The man's financial and housing needs were identified and effectively dealt with while he was at Nottingham. The resettlement team do not liaise with the healthcare unit because the continuity of care is healthcare's responsibility. It is not clear from the records whether contact was made with the community mental health service about the man's release. Given the short space of time between his release and his death, it is unlikely that such contact would have made any difference to the care the man received in the community. However, I note that in the Chief Inspector of Prisons' recent mental health thematic report, she calls for greater integration between healthcare and resettlement teams in prisons:

“Mental health inreach team's clients should all be referred to mental health services in the community, either by means of a GP letter or by direct contact with the community mental health teams in the area to which they are released. Such actions should be reliably communicated to resettlement staff and included in individual resettlement plans.”

57. In light of HM Chief Inspector's views and the findings of this report, the Head of Healthcare and the Head of Resettlement should consider how best they can improve communication between their respective departments.

### ACCT process

58. The man was subject to ACCT procedures for his first two weeks at Nottingham. The ACCT document was opened appropriately and good quality interactions were recorded on a regular basis. ACCT case reviews were held according to required timescales and the frequency of checks increased during one period of anxiety. However, no healthcare staff attended any of the case reviews for the first ACCT document and so those present did not realise that the man had not yet been prescribed his medication. After two weeks, the ACCT document was closed because the man told staff that his medication had been “sorted out”. During the final case review, the man “made good eye contact” and “appeared settled”. As scheduled, on 12 December 2007, an SO held the ACCT post closure interview and found that “identified areas of concern have been resolved”. The SO recorded that the man was now being looked after by the inreach team and was “settled on his medication”. The ACCT document remained closed.

59. On the man's first ACCT Caremap, (the action plan that accompanies an ACCT document), an officer identified that the man needed “to continue [medication] as prescribed”. On his second Caremap, another officer noted that the man needed “to continue his [medication] for his mental health issues”. Healthcare is identified as responsible for the implementation of both of these actions. Yet the man was not prescribed his medication until 20 December. I agree with the clinical reviewer's concern that the ACCT

document was closed on 20 December without any input from the inreach team. In fact, I am surprised at the limited attendance of staff at the case review. To be properly effective, case reviews must be multi-disciplinary:

**The Head of Safer Custody should ensure staff from a wider range of disciplines attend ACCT case reviews, particularly those identified as responsible for actions on the Caremap.**

60. The man self-harmed on 19 December. The occupational therapist told my investigator that she was surprised to discover that the man had self-harmed because it was not in his usual pattern of behaviour. She was on annual leave at the time, but told my investigator that she would have gone to see him had she been working that day. During interview, she said his self-harm might have meant that he was in a time of crisis.
61. The man told staff that cutting his arms was a “cry for help”. He wanted to move from D wing because it was too noisy. A transfer to a quieter area of the prison on F wing was quickly arranged. His previously closed ACCT document was reopened and the ongoing record followed on from the last observation on 30 November. I am pleased that the Suicide Prevention Co-ordinator, was concerned that no ACCT assessment was scheduled when the ACCT was reopened. In response to his note, an ACCT assessment was scheduled for the afternoon of 20 December, within the required period.
62. The assistant psychologist had never met the man before 20 December. She was the duty assessor for the main shift that day and therefore was called to assess the man by the senior officer on F wing. The assessor carried out the interview on the wing. She had access to the Concern and Keep Safe form raised by one of the officers and the observations made over the previous 24 hours. Her record of their discussion is comprehensive and the man seemed to discuss all of the issues that were affecting his mental state, for example, his medication, alcohol use, release and his experience on D wing. However, she described the man as confused and he did not seem able to explain what was bothering him. During interview, she said that the man convinced her that he was not considering suicide or at risk of further self-harm. He talked positively about his plans for Christmas and his determination to stop drinking. Yet she was concerned about him and recommended to the SO that the ACCT document should remain open. She did not record this conclusion under question 8 of the ACCT assessment, entitled, “agree what is to happen with the interviewee”. The SO did not have the opportunity to carry out the man’s case review during his shift.
63. Another SO took over the senior officer duties on the wing at 5.30pm for the evening shift. He noticed that the man’s case review was outstanding and arranged to carry it out. There is no evidence that the assessor’s recommendation was passed on to the SO on duty that evening. Although the SO told my investigator that he relied heavily on the assessment during the case review, the assessor had not recorded her recommendation that the ACCT remain open. In agreement with a wing officer and the man, the SO decided to close the ACCT document.

64. The SO explained his reasons for closing the ACCT document during interview. The man had told him that he self-harmed to get off a noisy wing. He had now moved wings and the SO believed the situation was resolved. During the case review, the man assured the SO that he did not need to be subject to ACCT procedures and was looking forward to his release. While I do not question SO's judgement, I am concerned about the limited amount of information available to him at the time of the review. During interview, the SO said that it was not unusual for the last two boxes on the form to be empty following an assessment. The boxes deal with any other issues that have not been covered in the interview and there are often no such outstanding matters. However, the assessor made a verbal recommendation that the ACCT should remain open and this should have been recorded.

**The Head of Safer Custody should remind staff of the importance of full completion of the ACCT assessment.**

65. Due to his move to F wing on 19 December, the second ACCT document was almost entirely completed by staff who did not know the man. Neither the SO on duty that evening nor the assessor had met the man or referred to his previous ACCT document from November. The man's intermittent anxiety, ongoing medication issues and bizarre behaviour are well-recorded in that document.

**The Head of Safer Custody should remind staff to use all available information about a prisoner to inform the ACCT process, including previous ACCT documents and intelligence from other parts of the prison.**

66. It is not possible to speculate whether the outcome would have been different if the man had been subject to ACCT at the time of his release. However, more thought might have been given to contacting the man's support network in the community, including his next of kin, so that they were aware of his recent self harm.

## **Detoxification**

67. When he arrived at both Leicester and at Nottingham, the man told staff that his drinking was problematic. He said that he drank whenever he had the money and that his offending was linked to his drinking. At Leicester, he met with a CARATS worker and was referred for a full assessment of his substance misuse needs. However, he was transferred before an assessment could take place. Nottingham has no record of him being referred to CARATS or the Alcohol Problems Advisory Service (APAS). The man did not refer himself to either service, despite them being well advertised on the wing and self-referral forms being readily available.

68. The man's lead clinician at the community mental health centre wrote to Nottingham with details of the man's drinking problems. The RMN was also concerned about them. When asked whether the man's alcohol use was

linked to his mental health issues he said, "It's 50/50 I think, it led to his depressive illness and then to deal with it he drank as well". He thought the man might not have understood that his drinking was linked to his mental health issues.

69. The occupational therapist said that she would have referred him to APAS in due course. However, her plan was to get him settled on his medication before exploring his other needs. The assistant psychologist discussed the man's desire to stop drinking during the ACCT assessment on 20 December. She said that, were it not for his imminent release, she would have referred him to APAS. Although she could not specifically recall whether she did so with the man, she said she would usually explain to prisoners in his position what services would be available to him in the community.
70. It is a matter of regret that the support set in train at Leicester was not continued at Nottingham. I understand that the priority was to stabilise the man's mental health before embarking on an exploration of his substance misuse needs. I agree with the recommendation of the clinical reviewer:

**The Head of Healthcare should ensure that patients with a history of intermittent alcohol abuse ("binge drinkers") are referred to APAS by the Primary Care Health team, following the first reception healthscreen.**

### **Mental Health**

71. According to Prison Service Order (PSO) 3050 which instructs prisons on the importance of continuity of healthcare for prisoners:

"When a prisoner enters reception a new clinical record is created. Efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with."

72. The man told staff that he had mental health problems during his first reception healthscreen on 13 November and his subsequent screen in Nottingham two days later. He told them that he was being treated by a community mental health unit, prior to being in custody. I agree with the clinical reviewer that:

"A system should be put in place for the timely identification of patients in receipt of community psychiatric care and prescriptions to have these verified and the prescriptions re-started within the prison at the earliest opportunity to ensure continuity of care and a minimisation of anxiety."

I am concerned that there was no system in place to ensure that the man's medical files were retrieved from the Mental Health Unit as a matter of course.

**The Head of Healthcare should ensure that a system is introduced whereby clinical records are requested from a prisoner's GP or relevant service within one week of a prisoner's reception where mental health or substance misuse needs are identified.**

73. The mental health referrals were received by the inreach team on 23 November. Neither referral is dated, although the staff nurse made an entry on 19 November when she made her referral. Upon discovering the man's file in the "pending" tray in the healthcare centre, she was not sure what action had been taken and what action was "pending". While I agree with the clinical reviewer that "the clinical records demonstrate the efforts and concerns of members of the Primary Health team and the Mental Health In-Reach team", I am concerned that the man's clinical records were not clear even to those using them to inform his care.

**The Head of Healthcare should remind staff of the importance of dating all mental health referrals.**

74. The occupational therapist described her role as one of the co-ordinators for the care of prisoners being looked after by the inreach team. There are three care co-ordinators in the team. Every Tuesday a meeting is held to allocate prisoners' assessments between the three of them. The man's referrals were allocated to her on Tuesday 27 November, four days after they were received by the inreach team. She arranged to meet him that day but he was in court. After a couple of failed attempts, she eventually saw him on 30 November.

75. The occupational therapist quickly identified that the man had been under the care of the Health Centre/Mental Health Unit before being taken into custody. She discovered that he was being prescribed a relatively low dose of Olanzapine and Venlofaxine by his community psychiatrist. She noticed that the man had not received medication since the end of October and was concerned about the impact this might have had on his mental state. She explained that doctors at Nottingham are reluctant to re-prescribe medication for patients under the supervision of the inreach team. Following her first appointment with the man, she contacted the community mental health service and asked for his prescription history to be faxed through. In fact, the RMN had already instructed the inreach administrative staff to retrieve the man's records the previous week. As soon as the occupational therapist received the man's prescription history, she became concerned that he had not received any medication while he was in Nottingham. She prioritised getting an appointment with a psychiatrist so that the prescription could be drawn up.

76. The RMN remembered the man from when he had worked with him in the community several years previously. He was struck by how different the man was in prison. He said that the man had "definitely" changed since he knew him in the community. When he first came across him in prison:

"... he seemed very desperate and of course he'd come in, I don't know if he'd been in two days but he'd had no medication and he was on some quite heavy duty medication and to just stop it, he was suffering so that's what I had to help him sort out."

77. In fact, by the time that the RMN saw the man he had been in custody for nine days in total, seven of them at Nottingham. The RMN was shocked that the man's medication had not been sorted out. He said that he had never had a problem accessing services when he needed to, but he was not prepared to comment on the actions of the inreach team. The occupational therapist described the problems she had accessing a psychiatrist:

“... they only come in once a week so it can be difficult. If one of ours [prisoners] is, say poorly on a Friday or something you can e-mail [the psychiatrists] but it's doubtful whether they are going to come see him till the Thursday.”

78. All of the psychiatrists attend Nottingham on a Thursday. If a prisoner urgently needs a psychiatric appointment, he must wait until the following Thursday. The occupational therapist also said that there is a high demand for such appointments and they can be booked for weeks in advance. The man was referred to a psychiatrist on 30 November and was eventually seen on 20 December, four days before he was released.

79. A psychiatrist saw the man on 23 November following an outburst on the wing. He was given 10mg of Olanzapine for the night. This prescription was not ongoing. The man received an occasional sleeping tablet (Zopiclone) over the following four weeks. It was not until after his appointment with the psychiatrist on 19 December that the man was finally prescribed 5mg of the antipsychotic, Olanzapine, and 75mg of the antidepressant, Venlafaxine. This is not a high dose of medication. Nevertheless, it had taken over a month to continue his prescription from his community treatment. It was also four days before his release.

80. The Chief Inspector of Prisons' thematic review on mental health highlights the problem of accessing psychiatrists and makes the following recommendation:

“Mental health practitioners should have access to psychiatrists trained in the specific competencies required to meet prisoners' psychiatric needs.”

In a local prison environment with an ever-changing population, prompt and flexible access to psychiatrists is essential for the delivery of effective mental health treatment. I am extremely disappointed at the length of time it took for the man to be re-prescribed the medication that he had received in the community. I agree with the clinical reviewer that:

**The PCT and the Head of Healthcare should review the service level agreement with the inreach team to achieve greater flexibility in meeting the needs of the prisoners, for example, access to psychiatric assessment and treatment through timely appointments.**

81. The occupational therapist described her frustration at not knowing when a prisoner is going to be released. As a care co-ordinator, she prioritised stabilising the man on his medication over other issues, for example

addressing his use of alcohol. She said that she regularly does not know how long she will be working with a prisoner, and this makes care planning difficult. I appreciate that there is a lot of uncertainty surrounding a prisoner's time in a local prison like Nottingham. Their movements are dictated by the courts. However, the inreach team must have the information available to them to inform care planning. The information is available on the Local Inmate Data System (LIDS).

**The Head of Healthcare should train all healthcare staff in the use of LIDS.**

82. The man was discharged on Christmas Eve. The occupational therapist and the RMN were in contact with the community mental health service, the community mental health service during the man's time at Nottingham. However, there is no record that contact was made about his release. This might be because the occupational therapist was on leave at that time. During interview, she explained that arranging cover for the inreach team is difficult because of the size of the team ("with it being Christmas and people having leave and that's just normal, you can't pick-up everybody else's caseload, it's not possible"). There was one member of the inreach team working over Christmas and his role was to continue with his own casework and react to any crises throughout the prison. While I appreciate the different functions of the Primary Care mental health team and the inreach team, the Head of Healthcare should consider the development of a protocol for covering leave periods between the two teams as a matter of good practice.
83. The man was supervised by mental health practitioners at Nottingham. They reacted reasonably to his self-harm and periods of anxiety. However, he could have benefited from a multi-disciplinary approach to his care. Certainly, his medication might have been sorted out more efficiently. While it is not possible to say that it could have been prevented, there are lessons to be learned following the man's death just two hours after his release.

## RECOMMENDATIONS AND GOOD PRACTICE

1. The Head of Safer Custody should remind staff of the importance of full completion of the ACCT assessment.

*The Prison Service accepted this recommendation. A notice to staff is to be produced reminding all staff of their responsibilities within the ACCT process. The Safer Custody team will reinforce requirements of local and national policy. Additional training will be put, as needed. The notice will be issued by 31 July 2008.*

2. The Head of Safer Custody should remind staff to use all available information about a prisoner to inform the ACCT process, including previous ACCT documents and intelligence from other parts of the prison.

*The Prison Service accepted this recommendation. The notice to staff, as mentioned above, will include reference to the use of all available information to inform ACCT decisions. Case Managers and Assessors will be reissued guidance. The notice will be issued by 31 July 2008.*

3. The Head of Safer Custody should ensure staff from a wider range of disciplines attend ACCT case reviews, particularly those identified as responsible for actions on the Caremap.

*The Prison Service accepted this recommendation. The notice to staff will also include reference to this effect. The notice will be issued by 31 July 2008.*

4. The Head of Healthcare should ensure that patients with a history of intermittent alcohol abuse ("binge drinkers") are referred to APAS by the Primary Care Health team, following the first reception healthscreen.

*The Prison Service accepted this recommendation. In their response, they said:*

*"Patients with a history of alcohol abuse are seen by the Substance Misuse team. We have two new APAS workers coming into post and we will be looking at referral criteria, assessment and treatment with the APAS workers. Nursing staff will be updated re referral procedures."*

*This is planned for implementation in September 2008.*

5. The Head of Healthcare should ensure that a system is introduced whereby clinical records are requested from a prisoner's GP or relevant service within one week of a prisoner's reception where mental health or substance misuse needs are identified.

*The Prison Service partially accepted this recommendation. Their response was, as follows:*

*“HMP Nottingham already has a system in place. Following consent from the patient at initial reception, a fax is sent requesting information within 24 hours. If no response, we contact again to request URGENT response. We will then contact the surgery if no response sent. Our GP has highlighted problems we have had in the past to our Patient Risk Manager re response times from GP surgeries. We are reviewing our current system.*

*This recommendation is scheduled to be implemented in July 2008.*

6. The Head of Healthcare should remind staff of the importance of dating all mental health referrals.

*The Prison Service accepted this recommendation. Staff will be sent a memorandum to this effect. However, they note that the introduction of a new computer records system means that the majority of referrals are electronically generated. This recommendation was implemented in June 2008.*

7. The PCT and the Head of Healthcare should review the service level agreement with the inreach team to achieve greater flexibility in meeting the needs of the prisoners, for example, access to psychiatric assessment and treatment through timely appointments.

*The Prison Service accepted this recommendation. They have forwarded the recommendation to the commissioner of services for further discussion and action.*

8. The Head of Healthcare should train all healthcare staff in the use of LIDS.

*The Prison Service has also forwarded this recommendation to their commissioner of services for further discussion and action. There is no date for implementation for these discussions.*

## **Good Practice**

The Governor wrote to the man's brother to express his condolences and those of his staff, and gave the details of his family liaison officer. This was despite the fact that the man died after leaving custody. I consider this to have been very good practice.