Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nelson Harvey, a prisoner at HMP Long Lartin, on 5 June 2024

A report by the Prisons and Probation Ombudsman

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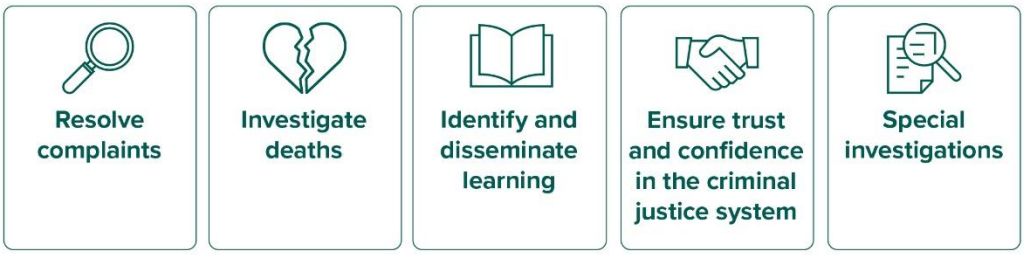
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Nelson Harvey was found hanged in his cell at HMP Long Lartin on 5 June 2024. He was 44 years old. I offer my condolences to Mr Harvey's family and friends.

Mr Harvey was supported using suicide and self-harm prevention procedures (known as ACCT) from May to December 2023. There was no indication that he was at risk of suicide or self-harm in the months after, or in the lead up to his death. I am satisfied that staff could not have foreseen Mr Harvey's actions.

I make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

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Summary

Events

1. On 30 May 2022, Mr Nelson Harvey was remanded in prison for sexual offences. In January 2023, he was sentenced to 18 years in prison.

2. In May, Mr Harvey's cellmate told staff that Mr Harvey had made a noose and was trying to hang himself. Staff started suicide and self-harm monitoring (known as ACCT).

3. On 20 July, Mr Harvey was moved to HMP Long Lartin. Staff continued ACCT monitoring until 5 December. By then, Mr Harvey had a job in a workshop and said he no longer had any thoughts of suicide or self-harm.

4. Over the next few months, Mr Harvey continued to receive support from the Inclusion Team (the integrated mental health and psychosocial service), though he was difficult to engage as he said very little. In March, a psychiatrist reviewed Mr Harvey and concluded that there was no clear evidence of mental illness. He assessed that Mr Harvey was unwilling to engage rather than unable to.

5. On 18 and 24 April 2024, Mr Harvey refused to go to the workshop. He did not give a reason why and so he received four negative entries for not going to work. He lost his place in the workshop.

6. On 1 May, because Mr Harvey had refused to go to work without a valid reason, staff downgraded his incentive level to basic. Staff removed Mr Harvey's television from his cell and restricted his wing association time.

7. A supervising officer (SO) held a 28-day incentive level review on 29 May. The SO recorded that Mr Harvey would remain on basic level as he had not made any attempts to find employment.

8. On 4 June, a member of the Inclusion Team saw Mr Harvey and told him he was being discharged from the team but could refer himself again if he needed support.

9. At around 5.10am on 5 June, during a routine check, an operational support grade (OSG) saw Mr Harvey hanging in his cell. She immediately radioed a medical emergency code. Staff responded and entered Mr Harvey's cell.

10. Staff started CPR but quickly realised that Mr Harvey had rigor mortis and stopped resuscitation attempts. A GP certified Mr Harvey's death.

Findings

11. We found that the ACCT process was, overall, well managed. After the ACCT was closed in December, Mr Harvey gave no indication that he was at risk of suicide or self-harm. We are satisfied that staff could not have foreseen Mr Harvey's actions.

12. The clinical reviewer concluded that overall, the care that Mr Harvey received was equivalent to that which he could have expected to receive in the community.

13. We make no recommendations.

The Investigation Process

14. HMPPS notified us of Mr Harvey's death on 5 June 2024.

15. The investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded and the investigator spoke to them on the telephone.

16. The investigator visited Long Lartin on 11 June. She obtained copies of relevant extracts from Mr Harvey's prison and medical records.

17. NHS England commissioned an independent clinical reviewer to review Mr Harvey's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with eight members of staff.

18. We informed HM Coroner for Worcestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Harvey's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She asked whether Mr Harvey had received the correct mental health care while at Long Lartin. This issue has been addressed in the clinical review.

20. We shared our initial report with HMPPS. They found no factual inaccuracies. HMPPS told us that a split regime referred to in paragraph 25 had been in place at the time of inspection but was not operating at the time of Mr Harvey's death.

21. We sent a copy of our initial report to Mr Harvey's next of kin. They did not notify us of any factual inaccuracies.

Background Information

HMP Long Lartin

22. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. All prisoners are accommodated in single cells. The healthcare contract is held by Practice Plus Group, with mental healthcare provided by Midlands Partnership Foundation Trust.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Long Lartin was in December 2022. Inspectors reported that levels of self-harm were the highest amongst similar prisons and that the rate of self-harm had doubled in the last 12 months and managers had no strategic plan to reduce self-harm. Inspectors did find some good examples of multidisciplinary work to support the individual care of some prisoners with complex needs.

24. Inspectors reported that living conditions on the older wings remained inadequate, and that most residential areas were poorly maintained. There were some serious heating and hot water failures during the inspection. The remote electronic unlocking system (Night-San) that allowed access to sanitation on the older wings had been upgraded and worked more efficiently, but it remained unacceptable that prisoners did not have free access to a toilet or running water.

25. A split regime was operating, which meant most prisoners were locked up either in the morning or afternoon. Many who were not working had just two and a half hours out of their cells plus the time it took to collect their meals. Vulnerable prisoners' access to education and work was too restricted.

26. A split regime was operating at the time of inspection but was no longer in operation at the time of Mr Harvey's death.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 December 2023, the IMB reported that the poor state of the infrastructure and inadequate level of maintenance support had failed to provide a safe and decent environment for prisoners.

28. The IMB noted that more prisoners were placed on a basic level in the reporting year, owing to an increase in refusals to attend work, the increased level of violence and the high number of illicit items being brought into the prison by drones. The average figures for incentives scheme privileges for the reporting year were: 50% on the enhanced level; 40% on the standard level; and 10% on the basic level.

Previous deaths at HMP Long Lartin

29. Mr Harvey was the eighth prisoner at Long Lartin to die since June 2021. Of the previous deaths, one was self-inflicted and six were from natural causes. There are no similarities between the findings from our investigation into Mr Harvey's death and the findings from our investigations into the previous deaths.

Assessment, Care in Custody and Teamwork (ACCT)

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

31. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed.

32. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011

Incentives Policy

33. Each prison has an incentives scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are three levels, basic, standard and enhanced.

Key work

34. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:

    - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.

    - Key workers must have completed the required training.

- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

35. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

36. On 30 May 2022, Mr Nelson Harvey was remanded in prison for sexual offences. He was sent to HMP Belmarsh.

37. On 20 January 2023, Mr Harvey was sentenced to 18 years in prison.

38. On 22 May, Mr Harvey's cellmate pressed the emergency cell bell and told staff that Mr Harvey had made a noose and was trying to hang himself. Staff removed the noose and placed Mr Harvey under constant supervision in the healthcare unit.

39. On 7 June, at an ACCT review, the case review team decided that Mr Harvey no longer needed to be under constant supervision but would remain on ACCT monitoring.

HMP Long Lartin

40. On 20 July, Mr Harvey was moved to HMP Long Lartin. Staff continued to monitor Mr Harvey under ACCT procedures.

41. On 21 July, a supervising officer (SO) held a multidisciplinary ACCT review. Mr Harvey was concerned that he had been moved to a prison that was a long way from his family, but apart from that he said he was fine and did not need to be supported by the ACCT process. The SO concluded that as Mr Harvey had been at Long Lartin for only one day, was far away from home and staff had not got to know him yet, ACCT monitoring would continue until he was more settled.

42. On 24 July, a recovery practitioner from the Inclusion Team (the integrated mental health and psychosocial service which offers support and treatment to men with mental health and/or substance misuse issues) assessed Mr Harvey. She recorded that he was struggling with low mood and poor sleep. She completed a care plan and recorded that Mr Harvey was to be offered psychosocial therapy to help with coping strategies and low mood.

43. Over the next few months, Mr Harvey's low mood remained the same and he continued to be monitored under ACCT. Staff recorded that Mr Harvey did not engage in ACCT case reviews and gave minimal responses to any questions that he was asked. Observations continued hourly.

44. On 20 August, an officer introduced himself to Mr Harvey as his assigned key worker. He noted that Mr Harvey seemed very quiet and did not make much eye contact. He said he did not need anything and would let staff know if he did.

45. On 18 September, a SO held a multidisciplinary ACCT review. He recorded that Mr Harvey was withdrawn and would not say whether he had any plans to self-harm. The case review team increased Mr Harvey's observations to four an hour and set the next review for 26 September.

46. Over the next month, staff held regular multidisciplinary ACCT reviews and Mr Harvey continued to be monitored under ACCT. Monitoring continued at four observations an hour.

47. On 10 October, a psychiatrist saw Mr Harvey for a psychiatric assessment. Mr Harvey told the psychiatrist he did not have any thoughts of self-harm or suicide. The psychiatrist diagnosed Mr Harvey with psychological distress caused by being in prison. He recorded that Mr Harvey did not have clinical depression.

48. On 18 October, a SO held a multidisciplinary ACCT case review. She noted that Mr Harvey was low in mood and said that he had not showered or washed his clothes all week. Mr Harvey said that he had no thoughts of suicide or self-harm so the case review team reduced ACCT observations to three an hour.

49. Mr Harvey's observations remained frequent and at least two an hour until 8 November. On 8 November, a SO chaired an ACCT case review and recorded that Mr Harvey was bright and engaging. He told the case review team that he was now employed in the prison workshop and was getting on well. Mr Harvey said that he had no thoughts of suicide or self-harm. The team reduced Mr Harvey's observations to three in the day and three in the evening.

50. On 13 November, Mr Harvey's key worker saw him for a key worker session. He recorded that Mr Harvey appeared noticeably more enthusiastic, was taking more care of his appearance, and was regularly attending work.

51. On 5 December, a SO chaired an ACCT case review and recorded that Mr Harvey was of clean appearance and engaged well with the team. Mr Harvey said that he was still attending the workshop and was interested in going to education. Mr Harvey said that he had no thoughts of suicide or self-harm. Staff stopped ACCT monitoring. She recorded that Mr Harvey would be seen every two weeks by the Inclusion Team for continued support.

52. On 14 December, a SO completed an ACCT post closure review. He recorded that Mr Harvey said that he was feeling better, the best he had felt in a long time.

2024

53. During the early part of 2024, Mr Harvey continued to attend the workshop. Staff in the workshop recorded that Mr Harvey did not engage very well in conversation and that he did not mix with other prisoners in the workshop.

54. On 5 March, a psychiatrist saw Mr Harvey for a review. He noted Mr Harvey did not engage with the review and when asked basic questions about how he was feeling, said, "I don't know", or shrugged his shoulders. He recorded that Mr Harvey was unwilling rather than unable to engage in the review. He concluded that there was no clear evidence of mental illness and Mr Harvey seemed unhappy with his life situation. He discharged him from psychiatry.

55. On 15 March, Mr Harvey's key worker saw him for a key worker session. Mr Harvey was at work in the workshop and the key worker took him to a side room to talk. He noted that Mr Harvey shrugged when he asked how he was. When he asked if Mr Harvey got along with the other prisoners, he said he did not speak to them. He noted that there had been incidents of other prisoners taking things from Mr Harvey's cell and asked if the issue had been resolved, but Mr Harvey shrugged. He also shrugged when asked if he wanted to move cells. When he asked if Mr

Harvey felt he was being bullied, he said, “not really”. The key worker recorded that Mr Harvey was choosing not to engage with him.

56. On 18 April, Mr Harvey refused to go to the workshop in the morning and afternoon. He did not give a reason and staff gave him two negative entries. Mr Harvey refused to go to work again on 24 April and received two more negative entries. He subsequently lost his place in the workshop.

57. On 1 May, staff reviewed Mr Harvey’s incentive level and downgraded him to basic for refusing to engage in purposeful activity. (Prisoners that are on basic level are not allowed a television in their cell, they have less money to spend at the prison canteen and their association time is reduced to far less than those prisoners that are on standard or enhanced level.) (There is no record of this review, but it is referenced in the review that was held on 28 May.)

58. On 5 May, an officer recorded that while undertaking standard cell checks, they noticed that Mr Harvey’s cell was unhygienic and had a strong, unpleasant smell.

59. On 24 May, Mr Harvey’s key worker saw him for a key worker session. He recorded that he asked Mr Harvey why he had stopped attending the workshop and Mr Harvey just shrugged. He suggested education and Mr Harvey said he would be interested and asked what classes were available. He said that he would find out and get back to him. He also discussed with Mr Harvey his personal hygiene and suggested that cleaning himself and his cell would improve his mental wellbeing. He recorded that Mr Harvey gave one-word answers or shrugged throughout.

60. Later that day, Mr Harvey’s key worker recorded that he had spoken with the education department and that they would see Mr Harvey the following week to advise him of any education classes that would be suitable for him. He also gave Mr Harvey a form to complete so that he could be put on a waiting list for maths and English classes.

61. On 29 May, a SO completed a 28-day incentive level review. The SO was not a regular SO on the wing and had been cross deployed that day, so he did not know Mr Harvey. He recorded that Mr Harvey would remain on basic level because he had not made any attempts to try and look for suitable employment. The review had no input from Mr Harvey and was not multidisciplinary (neither his key worker nor anyone from the Inclusion Team attended). The next review was set for 5 June.

62. On 30 May, Mr Harvey spoke to his wife on the phone. This was the last call he made before he died, and he said nothing of note. Mr Harvey did not receive any visits at Long Lartin.

63. On 4 June, the recovery practitioner saw Mr Harvey. She noted that Mr Harvey did not speak, he only nodded or shook his head. She told Mr Harvey that the psychiatrist had discharged him after his assessment in March. She explained to him what the Inclusion Team could offer and asked if he would like any help. Mr Harvey shook his head. She told Mr Harvey that she would discharge him from the Inclusion Team but he could submit an application to see them in the future if he needed support.

64. CCTV shows that Mr Harvey went into his cell at around 7.00pm that evening. At around 7.44pm, an operational support grade (OSG) completed the evening roll check. She had no concerns.

Events of 5 June

65. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to staff radio communications from 5 June. She also obtained information from West Midlands Ambulance Service. The following account has been taken from all sources.

66. At around 5.10am on 5 June, the OSG started the early morning roll check. When she got to Mr Harvey's cell, she opened the observation panel and could see Mr Harvey hanging from the door frame on the other side of the cell door. She immediately called a code blue (a medical emergency code used when a prisoner is unconscious). The OSG in the control room called an ambulance.

67. A minute or so later a custodial manager (CM) and a SO responded to the code blue and went into the cell. The CM cut the ligature from Mr Harvey's neck. He and the SO checked for signs of life and found that Mr Harvey had no pulse and was not breathing. The CM said in his statement that Mr Harvey was cold to touch, and his skin was a mottled blue colour.

68. The CM and SO briefly attempted CPR until a nurse arrived a minute later. The nurse briefly attached a defibrillator and continued to assess Mr Harvey. She noticed that rigor mortis had set in, and that Mr Harvey's hands were stiff. She asked staff to stop CPR.

69. The CM told the control room that Mr Harvey was dead. The control room updated the ambulance service who said that they would not attend.

70. At 10.27am, a prison GP certified that Mr Harvey had died.

Contact with Mr Harvey's family

71. At around 7.50am, a prison manager appointed two family liaison officers (FLOs). Both FLOs went to Mr Harvey's wife's address to break the news of his death.

72. A FLO maintained contact with Mr Harvey's family and offered ongoing support. The Prison Service contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

73. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer support) to identify prisoners most affected by the death.

74. After Mr Harvey's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

75. The prison posted notices informing other prisoners of Mr Harvey's death and offering support. The prison also deployed listeners to the wing to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Harvey's death.

Post-mortem report

76. The post-mortem report concluded that Mr Harvey died from hanging.

Findings

Assessment and management of risk

77. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures, known as ACCT, that staff must follow if they identify that a prisoner is at risk of suicide or self-harm.

78. Mr Harvey was supported using ACCT from May to December 2023. ACCT monitoring was started at Belmarsh and continued at Long Lartin when Mr Harvey was moved there in July. Staff held frequent and detailed multidisciplinary ACCT reviews and when they thought Mr Harvey's risk of suicide and self-harm had increased, they increased his observation levels accordingly.

79. From late 2023 until early March 2024, Mr Harvey appeared more settled and noticeably more enthusiastic. He attended the workshop, expressed interest in education and engaged well with staff. However, from early March, he became uncommunicative. He stopped attending the workshop and lost the job. Prison and healthcare staff repeatedly tried to engage Mr Harvey, but he often gave limited responses or shrugged his shoulders. He stopped looking after his own hygiene or that of his cell. A psychiatrist assessed Mr Harvey in March 2024 and concluded that there was no clear evidence of mental illness, and that Mr Harvey was unwilling to engage rather than unable to. Until 4 June, Mr Harvey was receiving support from the Inclusion team and was reminded of the services they offered. He declined support and was discharged.

80. While there was reason for staff to have some concerns about Mr Harvey due to his lack of engagement, Mr Harvey gave no indication to staff that he was at risk of suicide after ACCT monitoring was stopped. In the days leading up to Mr Harvey's death, there was no change in his mood or behaviour, and he gave no indication to staff that he was feeling suicidal. We are satisfied that staff could not have foreseen Mr Harvey's actions.

Incentives scheme

81. Long Lartin's local incentives policy says that all prisoners placed on basic level must be reviewed within seven days and if they are not suitable to return to standard level, further reviews must be held at least every 28 days (except for those identified as at risk of suicide and self-harm where reviews must be undertaken at least every 14 days). Staff did not follow this policy as Mr Harvey was downgraded to basic level on 1 May and then not reviewed until 29 May.

82. The policy says that prisoners should be included and able to contribute to incentive level reviews and that prisoners on basic level must be informed of the steps they need to take to return to standard level, making clear the specific behaviours and engagement they must demonstrate. The national Incentives Policy Framework says that wherever possible reviews should be multidisciplinary, particularly reviews of prisoners on basic level.

83. Mr Harvey's initial incentive level review was not recorded on his prison record. We have seen no documentary evidence of this review, other than a reference to it in the record of the 28-day review. There is no evidence that Mr Harvey was included in the review and no evidence of what he was told about the steps he needed to take to return to standard level.

84. There is no evidence that Mr Harvey was invited to the 28-day review on 29 May, or that the review was multidisciplinary. A SO recorded the targets that he had set but they were generic, and none was specific to Mr Harvey.

85. When asked about this at interview, a CM said that incentive level reviews at Long Lartin were multidisciplinary and that if a prisoner was under the care of the Inclusion Team, they would be invited. He also said that in his experience, incentive level reviews were completed more frequently than required as they were often done every seven days, rather than every 28 days. He could not say why the incentives policy was not followed for Mr Harvey.

86. Mr Harvey was on basic level for five weeks in the lead up to his death. From 1 May until he died, he was in a cell with no in-cell sanitation and no TV for long periods each day. On 5 May, staff noted that Mr Harvey's cell was in an unhygienic state with a strong unpleasant smell. Yet there was no evidence that wing staff tried to engage with Mr Harvey to understand why he was unwilling to go to work. We also saw no evidence that staff consulted with the Inclusion team to try to understand how they could best support Mr Harvey back into work and back onto standard level.

87. We bring these issues to the Governor's attention.

Clinical care

88. The clinical reviewer found that the health care provided to Mr Harvey was of a good standard and was equivalent to that which he could have expected to receive in the community. Mr Harvey was under the care of the mental health team, saw his key worker regularly and had two reviews with different psychiatrists who both concluded that Mr Harvey showed no evidence of mental illness or clinical depression.

89. Mr Harvey was regularly offered additional psychosocial support, such as counselling and other psychosocial interventions, to help him to develop coping strategies to manage his low mood. Mr Harvey declined all offers of additional support and when staff spoke to him his level of engagement was minimal.

Key work

90. Mr Harvey had only four key worker sessions while he was at Long Lartin. His assigned key worker said at interview that he had around six prisoners assigned to him who he was supposed to see monthly for key worker sessions. He said that he saw them rarely as he was very rarely assigned to key worker duties during his shifts and when he was, he was often redeployed to other duties due to staff shortages, or he ended up spending the whole time with the prisoners in crisis.

91. Mr Harvey was hard to engage, and it is possible that even if the key worker had met with him regularly, he would not have opened up much. Nevertheless, frequent key worker sessions are an important part of making prisoners feel supported and helping them progress through their sentence. Four key worker sessions in nine months is clearly falling far short of the expectations of the key worker policy.

92. The investigator asked the Deputy Governor about the provision of key worker sessions at Long Lartin. He said that because of significant resource issues, delivering the prison regime had been prioritised over key worker sessions. He said that the provision of key worker sessions had improved more recently and from November, Long Lartin would be able to meet the key worker requirements.

Inquest

93. At the inquest, held from 16 to 20 March 2026, the jury concluded that Mr Harvey died by suicide.

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