Investigation into the circumstances surrounding the death a man at HMP Long Lartin in May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

November 2008

This is the report of an investigation into the circumstances of the death of a man on 31 May 2007. At 9.05pm, the man was discovered hanging in his cell at HMP Long Lartin. Cardio pulmonary resuscitation was carried out but at 9.35pm he was pronounced dead. The man was 43 years old and had been in prison for eight years.

I would like to offer my sincere condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. My family liaison officer contacted both the man's mother and his ex-partner and mother of his three sons. I hope this report offers answers to their questions.

The investigation was led by my colleague. A clinical review was conducted on behalf of Worcestershire Primary Care Trust and the Associate Director of Nursing, and I am grateful for their assistance. I would also like to thank staff at HMP Long Lartin and in particular the liaison officer.

The man, a life sentenced prisoner, had been at HMP Long Lartin since June 2000. He had episodes of instability and was placed on suicide/self-harm monitoring ten times after telling staff that he felt like self-harming. However, no incidents of self-harm followed. On 11 May 2007, the man was moved to the vulnerable prisoners' wing fearing repercussions from a drug debt. Just less than three weeks later, following a number of unacceptable outbursts to staff, the man was taken off the enhanced regime of the Incentives and Earned Privileges scheme and placed on the basic level. Simultaneously, a self-harm monitoring document was opened as the man was refusing food and expressing his frustrations. Three hours later, the man was found hanging from the window bars in his cell. Efforts by officers, nursing staff and paramedics to resuscitate him failed.

I have made two recommendations and endorse those made by the clinical review. I have noted that the combination of an open ACCT form and basic regime may present as many risks as an open ACCT form and segregation. I must apologise for the delay in issuing this report.

The man Shaw CBE
Prisons and Probation Ombudsman **November 2008**

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SUMMARY

In July 1999, the man was sentenced to life imprisonment with a 16 year tariff. He spent his first 18 months at HMP Liverpool before transferring to HMP Long Lartin in June 2000. Upon reception into custody, the man was identified as having been a drug user and suffering from depression.

During his time in prison, the man was placed on self-harm/suicide monitoring ten times after telling staff he felt like self-harming. However, no incidents of self-harm followed and the monitoring document was always closed after a few days. The man was seen regularly by the nursing team as he frequently found life difficult to cope with and would become very stressed and agitated. This often led to confrontations with staff and other prisoners.

The man was placed on an anti-bullying monitoring form as he said he was in debt and needed protection on 10 May. The following day, he asked to be moved to A wing, the vulnerable prisoners' wing.

On 17 May, an entry in the wing observation book indicated that the man had a disagreement with an officer. He spoke with a nurse on 25 May about his ongoing concern about managing his anger and his violent thoughts towards others. The same day, an officer wrote in the wing observation book that the man appeared to have a negative attitude towards staff. There was another disagreement with staff on 26 May.

The man was issued with his first warning on 29 May, following an incident at the servery. His attitude was recorded as 'obnoxious, dismissive and horrible' by an officer. Later that day, the man told staff he was on hunger strike and so he was assessed by a mental health nurse. The nurse recorded that the man was very frustrated but the nurse was not unduly concerned about him.

The next day, a nurse tried to see the man but was not able to do so as the prison was in lockdown. On 31 May, The man had a further confrontation with the officer who had given him the first warning. He was issued with a second warning for his behaviour and an urgent review of his status on the Incentives and Earned Privileges scheme took place. It was concluded that the man should be downgraded from the enhanced regime to the basic one. Consequently, he moved cell and was given a limited amount of his possessions, which included his embroidery materials.

The man was told of the decision and, following his comments about feeling frustrated, the senior officer contacted the nursing team to request a nurse to see him. At 7.00pm, the nurse opened an Assessment, Care in Custody and Teamwork (ACCT) document because the man said that he had thought of suicide. He was to be checked by staff every hour.

The man was last seen alive by an officer at 7.55pm on 31 May 2007. At 8.13pm, he left his cell to use the toilet facilities, returning at 8.20pm. He was found hanging at the next check at 9.05pm. Cardio pulmonary resuscitation was carried out but he was declared dead at 9.35pm.

THE INVESTIGATION PROCESS

1. My colleague conducted a preliminary visit to HMP Long Lartin on 6 June 2007. She visited the cell where the man died. All the relevant documentation was reviewed and a chronology of events established. Feedback on the findings was given to the appointed liaison officer on a regular basis.

2. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity to speak with my investigator. A number of prisoners were spoken to at their request. However, not all of them had personal knowledge of the man and they were unable to provide my investigator with any new information.

3. My investigator met representatives from the local branch of the Prison Officers' Association and the Independent Monitoring Board. No specific concerns were raised about the man. My investigator also met the police officers who conducted the initial investigation of the death and liaised with them throughout their investigation.

4. A clinical review of the healthcare provided for the man was conducted, on behalf of the Worcestershire Primary Care Trust. My investigator conducted a number of joint interviews of medical staff.

5. The man's ex-partner and mother of his three sons took a lead role in liaison with the prison immediately after he died. She also acted as the main contact with my family liaison officer in respect of the investigation. The family had few questions to raise as the prison had largely been able to satisfy their initial need for information. Their most pressing question was why the man had chosen to take his life at this stage when there had been a number of previous occasions when he had seemed more depressed and at risk of self-harm.

6. Although we had been told that the man's mother, whom he had nominated as his next of kin, would not be able to contribute to the investigation, the manager of her care home was keen to establish her right to be kept informed. She was very distressed by her son's death and wanted to know more about the circumstances in which he had died.

7. A draft copy of this report was sent to the prison service. No factual observations were made and the report remains unchanged. The prison service provided an action plan in response to the recommendations and these have been repeated verbatim in the recommendations section. The man's family also received a copy of the draft report. Again, no factual observations were made.

HMP LONG LARTIN

8. Long Lartin is one of the five high security prisons. It holds some of the most serious offenders in the prison system. The prison has an operational capacity of 492. There are seven main residential units and a detainee unit, which are all supported by a healthcare, programmes and segregation unit. All cells are single occupancy.

9. In March 2007, the vulnerable prisoners' wing at HMP Long Lartin moved from Perrie wing to A wing as a result both of the growing population of vulnerable prisoners and to allow the wing to operate autonomously without impacting on the rest of the prison. A core of five experienced officers from Perrie wing moved as well. Other staff were recruited from those who had worked previously on A wing or the rest of the prison. A wing holds a maximum of 76 prisoners over three landings. The prisoners are either vulnerable due to the nature of their offence, because they have difficulty coping with the routine, or because they are seeking protection due to drug debts. Without this facility, the debtors might otherwise have been held in the segregation unit. The wing has a pool of 27 officers, three senior officers and one principal officer who has responsibility for both A and B wing.

10. Long Lartin's older style wings, including A wing, do not have toilets or washing facilities in the cells. During the night a computerised unlock system operates, known as the sanitation log system. Prisoners press their cell bell and wait to be automatically unlocked in order to use the bathroom on the landings. No more than one prisoner can be out of their cell at any one time. Therefore, if a prisoner is already out on their landing, a queuing system operates and each prisoner is unlocked in turn. Staff entering the wing can only do so once any unlocked prisoner has returned to their cell. Each person is allowed out of their cell for a maximum of 12 minutes.

11. At the time of the man's death, prisoners on A wing did not have access to the workshops, and so were unable to work. In recognition of the lack of employment facilities, they became eligible for employment pay of £13.50 per week even when they were not employed. (Two workshops opened in June 2007.) The other difficulty for A wing was the lack of offending programmes on offer. The man had been attending FOCUS (a programme for drug users) but was unable to continue once he moved to A wing because they were not able to run these groups separately from other prisoners.

12. A multi-disciplinary team of nurses, employed by Worcestershire Primary Care NHS Trust, staff the healthcare centre. Three teams provide mental healthcare – the primary care mental health nurses, a mental health in-reach team (MHIRT) and forensic psychiatric services provided by the Reaside Clinic. On reception to prison, a prisoner is first assessed by a member of the primary care team. Prisoners with a history of mental health illness or evidence of a severe and enduring mental illness are referred to the MHIRT and, where necessary, a psychiatrist. The primary care team manages any prisoner displaying other mental health problems, such as depression or a personality disorder. The man was supported by the primary care team.

13. The death of the man was one of three apparently self-inflicted deaths to have occurred in Long Lartin in 2007. However, the circumstances of the man's death do not have any common features with the others.

14. Long Lartin's food refusal policy outlines the actions to be taken by discipline and healthcare staff when a prisoner refuses food. For the first three days, staff are required to complete a food refusal form, and on the fourth day healthcare staff have to commence a care plan. It is not mandatory to open an Assessment, Care in Custody and Assessment (ACCT) document in every case of food refusal.

Incentives and Earned Privileges

15. According to the Prison Service Order 4000, the national aims of the Incentives and Earned Privileges (IEP) scheme are:

    - to encourage responsible behaviour by prisoners;
    - to encourage effort and achievement in work and other constructive activity by prisoners;
    - to encourage sentenced prisoners to engage in OASys and sentence planning and benefit from activities designed to reduce re-offending; and
    - to create a more disciplined, better-controlled and safer environment for prisoners and staff.

    "These aims are to be achieved by ensuring that privileges above the minimum are earned by prisoners through good behaviour and performance and are removed if they fail to maintain acceptable standards."

16. There are three tiers of the IEP scheme: basic, standard and enhanced. The main earnable privileges are extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, the opportunity to wear their own clothes, access to private cash and time out of cell for association with other prisoners. On entering custody, all prisoners are initially placed on the standard level and reviewed within the first month. Prisoners move between levels according to their behaviour and do not usually move from enhanced to basic without an intervening period on standard.

KEY FINDINGS

17. As explained earlier in this report, the man had periods of stability but regularly became agitated and found life stressful. Between his arrival at Long Lartin in 2000 and his death in 2007 he was placed on self-harm monitoring on ten occasions. Evidence from the observation book on C wing, where the man was located at the time, suggests that he was struggling to cope in March 2007. On 13 March, he was placed on a disciplinary report by an officer, education, for refusing a lawful order. The following entries are taken from the wing observation book:

> "Has family problems and is on new medication which is making him feel very aggressive towards staff. He is doing his best to keep it together and it was his wish that I put this in the book so that staff can be sensitive towards him." (15 March)
>
> "Phoned from HCC. (the man) came to hatch at treatments asking for rest in cell, reason being that he was going to kill an officer. Transpires that he missed treatments at weekend and blames staff for this. Security and duty gov informed. All staff on wing briefed." (19 March)
>
> "Became very angry and threatened man from canteen when he realised he did not have any. We told him we would deal with it but he would not listen, he said 'he had to sort it or else'." (23 March)

18. On 10 May, an anti-bullying monitoring form was opened as the man said that he was in debt and needed protection. He was moved the next day from C wing to Alpha Wing Support Unit (A wing) at his own request. He was located into cell A2-017. The man signed a Request for Support Status form and gave "bullying" as the reason why he was requesting to move. The size of the man's debt was unknown. Staff told my investigator that voluntary applications to go to A wing could be negatively perceived by other prisoners and could make it difficult for them to return to the main prison if, and when, any threat has gone.

19. The following entry appears in the Electronic Medical Information System (EMIS) for 11 May:

> "Transferred from C wing following an incident concerning weapons and a resultant lockdown. [NB. This was not the reason given on any other documentation.] Claims that certain prisoners were out to injure him 'and his mates', following a drugs situation, but staff stepped in and prevented any violence. Needless to say, he has had to discontinue his FOCUS course, but has been talking to the FOCUS tutors who understand his position and the priority of his safety on A wing. Claims he is no longer using heroin and is content with his present medication regime of Mirtazapine. He looks well, with clear skin, bright eyes and elevated mood, being much more reassured that his mother is getting regular attention from family friends on the out."

20. On 17 May, as part of an induction meeting, a Cell Sharing Risk Assessment (CSRA) form was completed. (A CSRA form is completed following any cell move and is reviewed regularly.) During the assessment interview, the man was asked how he felt about the situation. He replied “relieved to be away from C wing. Hoping to now keep off the drugs. Medication is now under control.” An officer was one of the three staff involved in this discussion with the man. He knew the man a little from his time in Long Lartin. At interview for this investigation, he recalled that the man was calm and did not seem worried. Although unable to recall whether the information came from the man or not, the officer formed the impression that things had deteriorated for the man. He thought the man had lost his job, as well as contact with his family, and had been taken off his courses.

21. The wing observation book covering 11 – 20 May 2007 was not made available to my investigator so it is not known if there were any entries about the man during this time.

22. On 17 May, in the man’s record of events sheets there is an entry by a second officer, “asked myself and (a third officer) if he could have cupboard for his cell. There were none available. Would not listen to (the third officer) when he said he would get one but talked to other inmates stating ‘we could not be bothered’. However one had previously been ordered for him.”

23. A nurse assessed the man on 25 May and recorded on EMIS:

> “Seen on A wing at the request of CPN. He came across as not depressed (sleeping well, eating well, concentration good), but reports ongoing concerns about his anger management and violent thoughts towards others. He appears to counter this by doing embroidery and this helps take his mind off it. He was very chatty in interview, and said that he finds it useful to talk through his concerns. He expects to see CPN on Monday next week.”

24. In interview, the nurse said that he had spent about 40 minutes talking to the man and felt that he was dealing appropriately with what was on his mind. He said that he was using embroidery as a coping strategy to distance himself from his difficulties. He said that he worried about not being able to continue with the FOCUS group whilst on A wing and that it would affect his chances of progressing through the system. He was also worried about his mother. However, the nurse said that he did not have any real concerns about him that day.

25. The same day, the officer wrote in his record of events sheet:

> “(The man) appears to have a very negative attitude towards staff when challenged over his loud music. I had to switch his electric off so that he could hear me. I told him he had disturbed education, and that people couldn’t concentrate in the classroom. He said ‘ar didums’, his attitude was that he wasn’t bothered.”

26. In interview, the officer said that he had received a complaint from the teacher about the man's loud music. He described the man's attitude as very blasé.

27. The officer said that there had been a further incident on 26 May. Although not formally recorded at the time, the officer later referred to it in the man's history sheet. The officer said that the man had made a negative comment to him and another officer when they were sitting on the 2s landing. The officer felt that it was quite obvious that the man had a problem with staff as he had not been allowed to move onto the 3s landing. (According to the officer, movements onto to the 3s were being monitored carefully as it was suspected that drugs were being dealt there.) In interview, the officer said that it felt to him as though the man might have had a problem with him.

28. On 29 May, the officer wrote in the history sheet:

> " when attending the servery today (the man) asked for two buns with his dinner, when told he can only have one he said stick it, when I explained that I only had enough for one each he said fuck off and dismissed my explanation. I believe (the man) has an ongoing problem with staff centred around him not being allowed to move cell. Very obnoxious attitude."

29. The officer wrote a similar entry in the wing observation book – "IEP warning issued for obnoxious, dismissive, horrible attitude at hotplate, said 'fuck off' when explained to regarding the bun issue."

30. A senior officer wrote in the man's record of events "warning issued (first one)". In interview, the senior officer explained that this meant he would have issued the warning to the man that day, using the opportunity to explain the appeal procedures and identify any outstanding problems to be investigated. The senior officer said that he could vaguely remember issuing the warning to the man. He recalled that the man had been negative and frustrated about the lack of employment and consequent shortage of money on A wing.

31. Later that day (29 May) at 4.45pm, an officer wrote in the wing observation book:

> " Came to the office to inform me that he is now on hunger strike, refusing everything. I asked him 'why'? he said because of everything ie. CPN not come to and seen him and other things that are happening. He wouldn't elaborate on this."

32. The officer added that the action she took was, "(The senior officer) informed, 2052a entry, H/C informed and CPN requested and informed." The next entry in the observation book was again written by the officer:

> "Seen by CPN @ 17.30hrs. CPN reports after seeing the man that he doesn't feel an ACCT is needed at this stage. He said he has stated he feels desperate and he did mention murdering someone to get out of here. CPN states he is very wound up and may 'kick off'. The CPN

said he will be supported by all CPNs over next few days and reviewed by himself on Friday. CPN states currently he is fit and well."

33. The nurse, who saw the man at the request of the officer from the wing, had known him for a long time. He said that the man was unhappy at being on A wing but "his attitude was confident, he had good eye contact and there was no overt suicidal ideation or self-harm intent." He recorded their discussion on EMIS:

> "Seen at 17.30hrs, after being informed by wing staff that (the man) had commenced food refusal. In conversation, (the man) calm and articulate but displaying underlying anger, particularly towards a named discipline officer who, (the man) claims, is targeting him, lying about him and 'digging me out'. He feels that he is trapped on A wing, where he cannot work or earn money, be subject to all the other restrictions of a VP wing and, especially, resume the FOCUS course necessary to obtain his much-desired transfer to a prison near his ailing mother. (has learned that his mum is not responding to knocks on her door by 'aunty' on a regular basis, and so is doubly anxious.) When asked when he commenced this food and fluid refusal, (the man) replied 'at dinner time'. He then said he would pursue this adamantly because 'it's the only thing to get me out of this f- place' and the only way he would obtain a transfer is 'to be taken out in a box'. He also mentioned that if he were transferred to normal location he would 'murder someone'. (The man) assured that a CPN would call on him in my absence and air his concerns. Wing officers informed of (the man's) angry threats."
>
> (NB. The family would like it noted that 'Aunty' is not a relative)

34. On 30 May, an entry written by the nurse in the healthcare communication book states, "Please can CPN see (the man) on Alpha for me sometime today (see EMIS), as he is between a rock and a hard place. I will see him Friday." Another member of staff has written next to this – "I tried but all locked down."

35. On the same day, an officer wrote in the wing observation book, "The man stated to me he is refusing food from the servery. Staff to observe the man". The officer completed a Record of Food Refusal following the three daily meal times. At breakfast and lunch, the form indicates that the man had taken food from the servery and that it was not known if he had taken any fluids. After tea, it is recorded again that he had not taken food from the servery and it was not known if he had taken fluids. The form indicates that this was day one of his refusal to take meals. Instructions at the bottom of the page indicate that "the wing manager is to ensure that completed forms are <u>delivered</u> to HCC at the end of each evening duty".

36. During the day, the man wrote a letter to his sister in Ireland which had not been sent by the time of his death. The man complained about two unnamed members of staff. He wrote:

> "The main reason for this letter is to tell you I've stopped eating and mean to go all the way to the end as these have pushed me over the edge. So if it go'es (sic) bad you can tell someone why I've had to do what I've done. They think they can just push us about and get away with it."

37. The man explained that he had lost his job and was going to be "taken off his medication". He finished the letter by saying that he would write another letter very soon.

38. The following day, on 31 May, the food refusal log was completed after each meal. At breakfast, the man is recorded as not having taken food from the servery but taken fluids. At lunch and tea, it is recorded that he had not taken food from servery and 'not known' if taken fluids. However, the officer who completed the lunch entry wrote in the man's wing record that "The man took milk from the servery". An additional piece of information says that he "has been taking fluids in his cell".

39. A nurse responded to a telephone request from the wing for someone to go and see the man as it was the third day three of his refusal of food. She said in interview that healthcare had not received any paperwork about the man, but she went to the wing anyway to see him at around 10.30am. (EMIS does not record the time of the entry. The entry was attributed to another staff member because, at the time, the nurse was sharing a computer and someone else was already logged in on the system when she made her entry). Her entry reads:

> "Day 3 food refusal. Looks well on wing, drinking cups of tea and water, BP 120/90. Said he will stop drinking in one week, seems determined to leave prison "in a bag". Spoken to (the man) about kidney damage and important to drink lots of fluid. CPN to see tomorrow. (the man) has a urine pot to return healthcare tonight or tomorrow. Explained to (the man) he will not be given meds while on food refusal."

40. The nurse explained that the man had said that someone had upset him. She told him that, if he did not want to talk things over with her, he could talk to the nurse who would be on duty the next day. The man appeared to be content with this. The nurse told the man that she understood that prisoners on hunger strike were not to be given their medication. She felt that he was fine about it. (The man had not collected his medication the night before but the reason for this is unknown.)

41. The man had said that he was drinking lots of water and tea and the nurse felt that he looked very healthy. He also told her that he had been on hunger strikes before and had always given up, but this time he was not going to. In spite of this, she was not unduly concerned as she thought that he would calm down and come to a compromise.

42. An entry, dated 31 May, in the wing observation book shows, "management check – close monitoring of (the man) please". A later entry reads, "now placed

on basic regime for initial period of 14 days”. A third entry says, “can all staff be aware this prisoner is on food refusal and paperwork must be filled out correctly”. A further entry “now on ACCT, hourly obs”.

43. Later that day, the officer again wrote in the man’s record of events booklet:

> “Whilst I was sat at the servery 2’s landing this afternoon (the man) approached me and questioned why I had given him a warning. I tried to explain why, however the man would not accept the explanation, he basically called me a liar and that I had fabricated it. He was talking in an aggressive fashion and was pointing his finger at me, in front of two officers said ’you are full of shit’.
>
> “I believe this behaviour still stems from (the man) not being allowed to move cells. I have had a number of ‘run ins’ with him and his negative attitude. Firstly on Sat 26th when staff were sat on the 2’s landing he said “do I have to walk around you lot all day” as our chairs were positioned so that the man had to walk around us to get passed. His comment was passed in an agitated way with a sarcastic edge.
>
> “Secondly the incident at the servery, and now this verbal attack. I believe this is a consistent poor attitude and behaviour. IEP warning.”

44. In addition to the entry in the record of events, the officer completed the Behaviour Warnings form. For the warning received on 29 May, he wrote “very obnoxious attitude when I explained the reason for only issuing one bun at dinner time, said ‘fuck off’ in a very dismissive fashion.” For the second and final warning the officer wrote, “for stating that I was ‘full of shit’ whilst letting me explain why I had issued the above warning. The man was talking in an aggressive fashion pointing his finger at me. Witnessed by the two officers.”

45. An urgent IEP meeting was held to review the man’s IEP level because he had received two warnings about his behaviour. The officer recommended that the man’s IEP status be reduced to basic for a period and this was endorsed by the senior officer. The principal officer was also required to comment and stated, “Entries in his wing file highlights a poor attitude towards staff and occurrences of abuse. This behaviour could have warranted adjudication procedures. I fully support the downgrading to basic.”

46. In interview, the principal officer said that he and the senior officer had discussed the situation and looked back through the man’s recent history sheets. He said that he asked why the man had not been put on a formal disciplinary report. The principal officer told my investigator that he thought staff were trying to give the man the benefit of the doubt the principal officer was only aware of his recent history. The senior officer said he thought that he and an officer had been present when he spoke to the man about downgrading him.

47. The officer said in interview that he, the other officer and the senior officer were in the office when the man was placed on basic. The officer said that the man

had expressed a wish to go to the segregation unit but the man had not been placed on report so this was not possible. The man had presented as “quite an impolite man” and there had been no change in his mood when he was in the office. The man left and then returned to ask what he was entitled to take with him on basic. He asked if he could have his hobby materials. The officer asked the SO who agreed that he could.

48. The senior officer considered the man to be very defensive during the meeting. He decided to refer the man to the CPN as he was presenting as frustrated about the situation on the wing and his position in general. He was set a number of targets – to remain adjudication free, and to comply with prison rules and regulations, officers’ requests and lawful orders.

49. In The man’s record of events booklet it was recorded:

> “ placed on the basic regime for x2 warnings and poor attitude towards staff. Compact issued and copy of the warnings……stated that he is still on food refusal H/care informed. Food refusal form started off.”

50. In interview, a nurse who said he had known the man for about six years, saw him between 6.15pm and 6.30pm on 31 May when the man went up to healthcare to collect his evening medication. He said:

> “I was slightly surprised to see him because I had heard he was on food refusal and wasn’t particularly happy as I heard it, but when he came up he was cheerful, quite smiley, we passed a joke but I can’t remember what the joke was … He took his medication which was Mirtazapine and he went the whole exchange lasted probably about a minute, minute and a half. I asked him how he was, he’d brought a specimen of urine up because of the food refusal that he had been on, which I tested in front of him and there was nothing in it at all, nothing abnormal and that was it basically.”

51. The nurse made a further entry in EMIS later in the day:

> “Bought up spec. urine pm fx=NAD. Appeared to be in good spirits, and joking/smiling. Took his Mirtazapine medication.”

52. A second nurse said he saw the man initially at about 5.45pm for 20 minutes before treatments were called and the man went off to collect his medication. The second nurse then saw him again upon his return and decided to open an ACCT document. The second nurse felt that the man appeared quite flat and he was aware that it was the third day that he was refusing food. He said that the man was angry about being put on basic. He said he spoke again about his frustration at not being able to do the FOCUS course and how this would affect his progress.

53. At 7.00pm, the second nurse opened the ACCT document as well as the Concern and Keep Safe form:

"On day 3 of food refusal – he is taking fluids. He has today been put on basic regime for being verbally hostile to an officer. He states that he feels increasingly hopeless about progressing. He would like to move from this prison. He tells me that he has had enough of life and intends to begin refusing water as well as food. He admitted to having thoughts of suicide, he's had for a while, but these are more intrusive due to current concerns. He did not tell me if he has any plans.

"CPN identified that if he started to refuse liquids and/or there was a deterioration in his mood and mental state then this should prompt an immediate review. In setting the immediate action plan with the senior officer and the man present they stated that he was to remain in his cell on A wing, have hourly observations overnight, access to phone the Samaritans and access to listeners". [Prisoners trained by the Samaritans to offer peer support.]

54. The second nurse's entry in EMIS read:

> "Seen on wing following concerns expressed by the senior officer. Put on basic today, due to 'verbal hostility' towards an officer. In interview, (the man) quite flat. Feels that the prison are disrespectful of his approach (says he says what he feels), and that he has little hope of progressing from this prison. He is on day 3 of food refusal, but says that from now on he plans to refuse drink too. He also cryptically said that he would like to do something more proactive to kill himself. He alluded to certain plans, but was vague. He said that his family concerns, on top of being on basic have 'worn me down'. I d/w [discussed with] The senior officer, and felt little option, but to open an ACCT on him – hourly obs. (The man) was ambivalent about this. He is to be assessed tomorrow."

55. In interview the second nurse said:

> "…I asked him if he had any thoughts of harming himself and he was vague really. He didn't really, he said he didn't have any plans but he did state that he was thinking of finding a more proactive way of getting out of prison… And that was really what triggered me into speaking to the SO about opening the ACCT."

56. According to the second nurse, the man did not seem to be particularly concerned when he told him that he was putting him on ACCT monitoring. He thought he told him that he would be monitored every hour. The second nurse said opening the ACCT was really about monitoring and supporting the man rather than believing that he was going to harm himself. He added, "if I'd really thought that he was going to do something then I would have put him on more observations." (Within 24 hours of opening an ACCT, an in-depth assessment has to be carried out and this would have taken place the next day.)

57. At 7.10pm, the wing was locked up with all prisoners in their cells for the night. At 7.55pm, an officer wrote in the man's ACCT, "in cell lay on bed listening to

music". In interview, the officer said that the man looked at him but did not acknowledge him. The officer was not surprised by this as he felt that the man was a quiet person and not the sort to engage with staff.

58. At about 8.00pm, the night sanitation system comes into operation on A wing. The landings are locked and movements are automatically recorded. The log indicated that the man came out of his cell at 8.13 pm and was locked up again at 8.20pm. CCTV indicates that the man did not stop at any other cell to speak to anyone.

59. Staff cannot enter the wing until an unlocked prisoner has returned to their cell and the door automatically locked again. The officer said that he put his key into the system at 8.50pm to make his ACCT checks and was placed in the queuing system. Another prisoner was out at the time and he told my investigator that he recalled seeing an officer standing waiting to come on the wing when he returned from the toilet.

60. At 9.05pm, the officer checked on the man and, after switching on the light, discovered him suspended from the cell window. The man had made a ligature from his embroidery. The officer immediately used his radio to call a code blue (which indicates the nature of the incident – in this case, hanging) and waited for staff to arrive. (All radio calls go the communication room who keep their own log. The clock in the communication room was six minutes fast and, according to their record, the call was made at 9.12pm.)

61. When the staff arrived, the officer who found the man requested the cell door to be released via the electric locking system as he did not have a key to the cell. The officer said in interview that, as he was alone, he waited for the other officers to arrive in case it was not a genuine situation. He estimated that officers arrived at the cell very quickly in response to the call. The communications record showed that the door was unlocked at 9.13pm which indicates that it was opened one minute after the officer's code blue call. An ambulance was called by the communication centre at 9.14pm. Upon entering the cell, a senior officer cut the ligature whilst the other officers held the man's weight. They placed him on the bed and checked for a pulse but one was not found.

62. The only nurse on duty overnight at the prison responded to the code blue call and attended the cell with the emergency equipment. He had been in the treatment room in the healthcare department, located next to A wing. Although he had to unlock at least two gates, he estimated that it only took him about two to three minutes to get there. When he arrived, the man was on the bed. The night duty nurse checked for signs of life. He said that there was no pulse, no breathing and the man was cold and looked blue (cyanosed). The man was placed on the cell floor and the night duty nurse began cardio pulmonary resuscitation (CPR) with oxygen input via a mask. He requested that the defibrillator be collected and brought to the cell and set this up while three officers took turns doing cardiac massage. The defibrillator indicated that an electric shock should not be administered. They continued CPR until the paramedics arrived. At 9.35pm, the paramedics pronounced that the man had

died. Following the man's death there was a hot debrief in which all staff involved were advised of the care and welfare services available to them.

Contact with the man's next of kin

63. The next morning the prison's family liaison officer and a governor travelled to Liverpool to break the news of the man's death to his family. One of the man's sons and the son's partner were at home. The son telephoned his mother and she came to the house together with another of the man's sons. The man's elderly mother, and nominated next of kin, was living in a care home. The family and prison staff then went to the care home to break the news to the man's mother. It was agreed that his ex-partner would act as the point of contact for the family.

64. When contacted by my family liaison officer, the man's ex-partner only had praise for the way they had been treated by staff and singled out the prisons family liaison officer for special mention. She and one of her sons had visited Long Lartin and had been able to see the man's cell. They were told at an early point not to worry about funeral expenses and were reassured that the prison would meet all the costs. The prison met all their requirements in accordance with PSO 2710. All of this is good practice that reflects well upon Long Lartin and upon the Prison Service as a whole.

ISSUES

Change from enhanced to basic level of IEP

65. On 31 May 2007, wing staff deemed the man's verbal outbursts to warrant reduction from enhanced to basic. Prison Service Order 4000, published on October 2006, deals with Incentives and Earned Privileges. It states that the "fast tracking of prisoners from enhanced to basic must be avoided except in the most serious of cases of misconduct, e.g. assault." Long Lartin's local IEP policy, issued in August 2006, states that "in only the most extreme of circumstances will prisoners regress from enhanced to basic (i.e. conclusive proof of bullying); usually they will only regress from the enhanced to the standard regime or from the standard to the basic regime." (p.9)

66. I am not minded to be critical of the way in which the IEP review was conducted or to question whether staff were familiar with the policy. This was clearly a question of judgement. Nevertheless, I am unconvinced that the man's behaviour was of the most serious nature to warrant his level of IEP to be downgraded from enhanced to basic. Equally, there were alternative ways to have dealt with the man – he could have been placed on disciplinary report and dealt with by way of the adjudication process. Although I have chosen not to make a formal recommendation, the Governor will wish to ensure that the IEP policy is being properly implemented.

67. I have frequently pointed to the risks when a prisoner subject to ACCT is placed in segregation. ACCT and basic regime may pose similar dangers. The National Offender Management Services' Safer Custody and Offender Policy Group may wish to consider if further guidance on this matter is justified.

68. In allowing the man access to his embroidery, staff were acting contrary to Long Lartin's own policy which states that prisoners on basic will not have access to cell hobbies equipment. However, given that the man was placed on an ACCT at this time, I believe it to be entirely appropriate that he was allowed something to keep himself occupied. No one could reasonably have anticipated he would use the embroidery to make a ligature. In any event, there were other things he could have used.

ACCT

69. The man's ACCT required him to be observed once an hour every hour. This is the most infrequent interval of observations and reflected the perception of the nurse who felt that the man's risk to himself was small. I do not criticise this decision. However, observations should be carried out at varied times so as to avoid any predictability. The man was checked at 7.55pm and 9.05pm when he was found hanging. As the wing had gone into night sanitation, the officer was waiting at the wing door from 8.55pm. By the time he reached the man's cell, it was 70 minutes since he had last been seen. Unfortunately, the officer was prevented from entering the wing because another prisoner was out and so he had to wait in the queue. This is a unique problem for those prisons where night sanitation is in use.

The Governor should remind staff to take account of the potential delay that can occur as a result of the night sanitation system. The timings of ACCT observations should take this factor into consideration.

The Governor should remind all staff that ACCT checks should not be carried out at predictable times.

Alpha wing

70. In March 2007, Alpha wing took over the role as the vulnerable prisoners' wing. The prisoners included those needing protection as a result of their offence and also those with drug debts. Some staff interviewed by my investigator estimated that the drug debtors made up 60 per cent of A wing's population. Clearly, this creates a complicated mix of prisoners to monitor. Prisoners with drug debts may have to spend a considerable length of time there as it becomes difficult for them to return to the main prison. The only option might be for them to try and be transferred to another prison. At the time of the man's death, the wing had limited availability of workshops and education. I am encouraged that facilities and opportunities for A wing prisoners have improved considerably since then and I make no recommendation on this point.

The clinical review

71. The clinical review was undertaken by Worcestershire Primary Care Trust. The authors concluded that there appear to have been some minor errors regarding interpretation of local policies, completion of records, as well as some delay in immediate response upon discovery. However, it is unlikely that correction of any of these errors would have made any substantial difference to the outcome or prevented the prisoner's death.

72. The authors posed a number of questions, some of which lead to recommendations. I have repeated their discussions in full and endorse their recommendations.

Were appropriate Food Refusal policies and procedures in place and were they followed?

73. A Food Refusal Policy was in place but it was not followed and appears to have been understood and interpreted differently by individuals. The man had been refusing food since teatime on 30 May and had not taken fluids since the morning of 31 May. His medical record states that wing staff had informed the CPN on 29 May that he had begun refusing food at 5.30pm although the Record of Food Refusal was not completed until the following day. The form stated that the man had taken food from the servery at breakfast time and lunch time but not at tea time. The man was seen in healthcare on 31 May because of "day 3 food refusal" but forms were only completed for days 1 and 2, that is 30 and 31 May. Upon interview the nurse who had seen him that morning said that they had not received any food refusal forms in healthcare and that officers had phoned and told healthcare he was on day 3 of food refusal. There

appears to have been confusion as to which day of food refusal the man was actually on, which forms needed to be completed, where the forms were retained and therefore the policy was not followed.

74. On the morning of 31 May, the man was seen in healthcare to check his blood pressure and urine. It is recorded in his medical record that he was told he would not be given his medication while he was refusing food. Upon interview, the nurse said that she had been told that no medication was to be administered to prisoners who were refusing food. However at 6.15pm, the man was given his medication. In interview the nurse who gave him his medication understood that there were some medicines that would affect the stomach if given while refusing food but the nurse thought that the antidepressant tablet was not one of those. The policy states that a review of medication should be arranged on the third day and physical observations commence and the CPNs be informed on the fourth day.

75. The clinical reviewers state that the Food Refusal Policy is unclear and was not followed by either prison or healthcare staff. Each nurse had a different understanding of the medicines policy and whether or which medications should be administered. There was no policy or procedure regarding the action to be taken when prisoners either do not collect their medication or are unable to collect it due to the prison being locked down.

The Governor and healthcare manager should review the medicines policies and the food refusal policy to ensure that staff understand and follow the policies.

Is the documentation and record keeping adequate and appropriate?

76. The record keeping for the man's food refusal did not follow the policy. The day (day 1, 2 etc) should have been entered and the records should have been sent to healthcare. The medical records had improved as the EMIS computer system had been introduced and so entries had been printed, rather than handwritten, since February 2007. However when staff log into the EMIS system it does not include a time entry, which might be helpful. Also EMIS entries were insecure, as staff are able to enter EMIS by using the log in of other staff and appeared to be able retrospectively to change entries.

77. The man was not seen on 30 May although it had been recommended by the CPN who saw him the previous day and recorded the request in the CPN communication book. A CPN had annotated against the entry that the man could not be seen because the prison was locked down. If a healthcare professional is concerned and recommends a prisoner needs to be seen, this information should be recorded on the medical record.

The healthcare manager should make sure that whenever a healthcare professional or CPN recommends that a prisoner is seen on a particular day, and then subsequently the prisoner is not seen due to reasons such as lock down, that the full reasons for not making contact are entered into the medical record.

Was the immediate response to the man's discovery appropriate and timely?

78. It appears that prison officers reacted quickly and appropriately to the discovery of the man. They had cut the ligature and laid the man down, activated the code blue signal and called the ambulance service. However, they had not commenced CPR and the review panel were unable to ascertain whether they had received CPR training. The availability and training in the use of face masks could be a factor in the likelihood whether a prisoner receives CPR from prison staff. Given the restrictions on the movement of healthcare staff through the prison, immediate first aid falls to the officers. Anything that makes it more likely that they will be able to do this, in the man's case by giving CPR, could reduce harm and injury.

    The Governor should encourage and support first aid training for staff in contact with prisoners and ensure the availability of face masks for CPR.

79. The night duty nurse was in the treatment room in the healthcare unit when he heard the code blue call. He immediately gathered the code blue emergency bag and rushed to the wing and arrived within two to three minutes, which the clinical reviewers judge to be reasonable given the prison layout and restrictions. Unfortunately, the defibrillator bag was not initially taken with the emergency bag and an officer had to return to healthcare to collect it.

80. The nurse commenced CPR and when the defibrillator arrived it was set up but announced no shock was required. The defibrillator was attached to the man within five minutes of the code blue call. The nurse continued with CPR for a further 13 minutes until the paramedics arrived. Although there was a delay in obtaining the defibrillator, the man appeared dead when the nurse first reached him and had no pulse, was not breathing, was cyanosed, cold and had been incontinent of urine.

81. The call to the ambulance service was prompt and the time taken by the ambulance crew to arrive was reasonable given the nature of the prison. The paramedics said that they thought the prisoner had been dead for quite a while.

82. The defibrillator bag is always stored next to the code blue emergency bag and should be picked up with the emergency rucksack. However, the healthcare unit was being refurbished at that time and the bags were not in their usual place but in a different room, the doctor's offices. The different location of the bags that night does not appear to have delayed the nurse in collecting the emergency bag but might have been the reason why the defibrillator bag was not taken as well.

83. The nurse was in healthcare when he heard the code blue so was able to access the emergency bag and head to the wing. If the nurse had been on another wing he would have had to get back to healthcare first to collect the code blue bag and defibrillator which would have caused further delays.

The healthcare manager should review the code blue emergency bag. The defibrillator should not be stored separately but be contained within the bag so that only one bag needs to be collected.

To improve the immediate response to emergencies, consideration should be given to providing better access to a code blue bag with defibrillator. A resuscitation bag could be located within all wings or in particular Alpha wing and other specific parts of the prison that are the furthest from healthcare.

The clinical reviewers recommend further consideration be given to the healthcare staffing complement at night time.

Conclusion

84. The man struggled to cope and to keep his emotions under control. This led to regular confrontations with staff and other prisoners. He was placed on self-harm monitoring ten times but had never actually harmed himself. We cannot be certain of the reasons why he did so this time. However, finding himself in debt and needing protection was likely to have caused him further anxiety, as was being placed on the basic regime.

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RECOMMENDATIONS

1. The Governor should remind staff to take account of the potential delay that can occur as a result of the night sanitation system. The timings of ACCT observations should take this factor into consideration.

Accepted. Staff are aware of the delay that can occur. This will also be noted on Induction training and ACCT training that is locally delivered.

2. The Governor should remind all staff that ACCT checks should not be carried out at predictable times.

Accepted. This is already part of national guidance and to be monitored by the wig managers and Safer Custody Manager in the establishment.

Recommendations from the clinical review

3. The Governor and healthcare manager should review the medicines policies and the food refusal policy to ensure that staff understand and follow the policies.

Accepted. The in-possession medicines policy has already been reviewed in March 2008 and the Food Refusal policy is in its final draft and awaiting ratification.

Notices will be issued to ensure staff understand the changes. Some of the changes make the policies clearer and residential managers will ensure there is compliance with the policies.

National policy for the Clinical Management of People Refusing Food in Immigration Removal Centres and Prison to be published shortly.

4. The healthcare manager should make sure that whenever a healthcare professional or CPN recommends that a prisoner is seen on a particular day, and then subsequently the prisoner is not seen due to reasons such as lock down, that the full reasons for not making contact are entered into the medical record.

Accepted. This has been put into place. Administrators input this information onto EMIS as a matter of course.

5. The Governor should encourage and support first aid training for staff in contact with prisoners and ensure the availability of face masks for CPR.

Partially accepted. There is 24 hour healthcare provision.

There are some staff who are First Aid at Work trained and newly trained prison officers are trained in emergency first aid on their training course.

Legislation changes next year will mean the introduction of an Emergency First Aider in the Workplace qualification. This will be a one day course which will enable more staff to be trained.

6. The healthcare manager should review the code blue emergency bag. The defibrillator should not be stored separately but be contained within the bag so that only one bag needs to be collected.

Partially accepted. To store the defibrillator inside the code blue emergency bag would make the combined weight over 11kg and this may be too heavy to be safely carried.

This will be reviewed and consideration given to how this is stored – currently they are stored separately but side by side. Consideration will be given to purchasing other defibrillators.

7. To improve the immediate response to emergencies, consideration should be given to providing better access to a code blue bag with defibrillator. A resuscitation bag could be located within all wings or in particular Alpha wing and other specific parts of the prison that are the furthest from healthcare.

Partially accepted. As above. The availability of resuscitation bags will be reviewed.

8. The clinical reviewers recommend further consideration be given to the healthcare staffing complement at night time.

Accepted. Already accepted locally and in progress. There will be 1 Health Care Assistant and 1 qualified member of nursing staff each night. The recruitment process is to start shortly as the formal 3 month consultation period is happening now.