Investigation into the circumstances surrounding the death of a man at HMP Frankland in August 2009

Report by the Prisons and Probation Ombudsman for England and Wales

September 2011

This is the report of an investigation into the circumstances of the death of a man at HMP Frankland. He was found hanging in his single cell in August 2009. He was 33 years of age.

I extend my sincere condolences to all those affected by his loss. I also apologise for the delay in issuing this report, and for any additional distress that this may have caused.

The investigation was conducted by one of my colleagues. A clinical review was carried out by the local Primary Care Trust. I should like to thank the Governor of Frankland and his staff for their co-operation.

The man was serving a very lengthy sentence. He was initially remanded into custody in February 2007 and had been sentenced to life imprisonment for a minimum term of 27 years. He made repeated statements about not wishing to serve that length of time and he harmed himself many times, often with almost fatal consequences.

For the majority of his time in custody the man was maintained on the prison's suicide and self harm prevention measures. I have found that staff at Frankland tried very hard to motivate him and persuade him that he had things to live for. Staff resuscitated him on several occasions, thereby saving his life.

In the final few days before his death the man was located in Frankland's 'progression unit'. It was hoped that he might alter his self-harming behaviour and if that happened, it might have been possible to transfer him to a prison closer to his partner's home. Unfortunately, the man took his life. After his death a note was discovered in which he said farewell to his partner.

I am not certain what else Frankland could have done to prevent this outcome over and above the strenuous steps they had already taken and I make only one recommendation. This concerns obtaining additional advice about prisoners at long term risk of harming themselves

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

Jane Webb
Acting Prisons and Probation Ombudsman **September 2011**

CONTENTS

Summary	4
The Investigation Process	5
HMP Frankland	6
Prisoners who are at high risk of suicide	7
Key Findings	9
Additional information from prisoners	25
Issues	27
Conclusion	32
Recommendations	33

SUMMARY

The man was a 33 years old man and was found hanging in his single cell at HMP Frankland in August 2009. He had been in prison custody since early 2007. He was serving a life sentence for a minimum term of 27 years.

For the most part of his two and a half years in custody the man was monitored through the ACCT[1] process. That included periods where he was being monitored through constant supervision. More typically, his level of observations tended to be set at around four or five per hour. The reason for this was because of his repeated assertion that he would not serve such a long sentence, but would instead take his life at some stage.

The man harmed himself many times, sometimes significantly, and he used several different methods: he took a significant overdose of medication on one occasion, he used ligatures, and he cut himself. On four occasions he came close to hanging himself but was found by staff in time and resuscitated. On other occasions, he lost so much blood from his self-inflicted cuts that he had to be sent to outside hospital for transfusions.

The man's partner lived in Liverpool. Due to the distance between that city and County Durham (where Frankland is situated), the man wanted to move to a prison in the North West, such as Wakefield. Frankland would have found it difficult to persuade Wakefield to take him due to the problems managing his self-harming behaviour. The man was aware of this. To try to resolve this problem he was moved to Frankland's 'progression unit' with the hope that he might alter his behaviour. He moved there on 17 August 2009, four days before he died.

At an ACCT case review on 20 August, the man's observations were reduced from four to two per hour. (Until 14 August he had been maintained on constant supervision for the previous nine days. On that day his observations were reduced to five per hour and on 17 August were reduced to four per hour.)

At just after 1.00am on 21 August, an officer looked into the man's cell and saw him sitting on the floor with a ligature running from his neck to the window frame. Staff went into the cell, cut the ligature, and attempted resuscitation. Ambulance paramedics also attempted to resuscitate him and they took him to hospital where efforts continued. Unfortunately, all their attempts proved unsuccessful and he was pronounced dead at 2.20am.

The man left a note in his cell in which he said "goodbye" to his partner, telling her that he could not "take the pain anymore".

I make one recommendation. This is about the seeking of advice on the management of prisoners who are at a high risk of suicide. Two additional recommendations are made by the clinical reviewer, both of which I endorse.

[1] ACCT (Assessment, Care in Custody and Teamwork) is the Prison Service process used for monitoring and supporting prisoners deemed at risk of self-harm or suicide.

THE INVESTIGATION PROCESS

1. The investigator first visited HMP Frankland on 24 August 2009 when he met several of the staff including one of the prison chaplains and a representative from the Prison Officers' Association. He also met the Chair of the Independent Monitoring Board. Frankland's Governor was not in the prison on the day of the investigator's visit.

2. The local Primary Care Trust (PCT) agreed to carry out a review of the man's clinical care and treatment at Frankland prison. Having appointed a clinical reviewer, the PCT reallocated the review to a different reviewer. This contributed to the delay in the issue of this report.

3. The investigator interviewed 20 members of staff. He also interviewed four prisoners who knew the man.

4. One of my Family Liaison Officers contacted the man's partner. She was concerned about the regime on the 'progression unit' where her partner died. In particular, that he had no television or any other privileges and would have been locked in his cell for most of the day. She raised several other matters about events after his death which are outside my remit and which I have brought to the attention of the prison.

HMP FRANKLAND

5. HMP Frankland is a high security prison in County Durham. It holds over 800 prisoners convicted of serious offences.

6. Frankland's healthcare unit, where the man spent a considerable amount of time, contains high visibility cells. These cells are used for prisoners subject to constant supervision when at high risk of self-harm. Prisoners in healthcare are permitted to have in-cell televisions.

7. The last inspection of Frankland by Her Majesty's Chief Inspector of Prisons was an announced inspection in February 2008. In the introduction section of her report the then Chief Inspector wrote:

   > "Frankland holds some extremely challenging prisoners: [including] those with … a history of extreme violence … and some with severe personality disorders. These groups contain prisoners who are dangerous, but also prisoners who are vulnerable …"

8. Later in her report she wrote about the prison's healthcare in-patient unit:

   > "… The PCT had introduced a no smoking policy throughout healthcare and there had since been a dramatic drop in the number of prisoners admitted. Smokers were offered smoking cessation support …"

9. In their report on Frankland for the period 1 December 2007 to 30 November 2008, the prison's Independent Monitoring Board (IMB) commented on the newly established G4 Progression Unit where the man was accommodated when he died. This unit was designed to deal with prisoners who had fallen into a cycle of poor behaviour leading to them spending lengthy spells in the segregation unit. The IMB spoke positively about the early signs of identifiable changes for the better in the behaviour of several prisoners transferred from the segregation unit to G4. The IMB also reported that the views of prisoners in G4 were mostly positive.

10. Since the Ombudsman took on responsibility for the investigation of all deaths in prison custody in April 2004 there have been three apparently self-inflicted deaths at Frankland, including that of the man. There were no matters arising in either of the other two deaths that were of particular significance to his death.

PRISONERS WHO ARE AT HIGH RISK OF SUICIDE

11. Prison Service Order (PSO) 2700 provides advice and guidance on the ACCT process for dealing with prisoners who are at risk of self-harm or suicide. The advice given about setting levels of observation is not explicit. Instead, staff are expected to use their own judgement in deciding what would appear to be the appropriate level of observations for a prisoner in any particular set of circumstances. Advice given under the heading "Reducing the level of observation and engagement" states that:

 "Acute suicidal crisis may be temporary and one aim of the case reviews should be to reduce the level of supervision progressively, substituting alternative supports as the prisoner's condition improves. This will involve some degree of risk taking as it involves the prisoner being allowed to gradually take more responsibility for [himself]. Constant supervision must only be for the shortest time possible …

 "Where the prisoner is still on constant supervision beyond a week, this may be a sign of lack of confidence and fear of blame in staff …"

12. The PSO recognises that with the great majority of people, suicidal crises are short-term and pass quickly. The PSO also accepts though, that there are other prisoners whose heightened risk of suicide is long-term. One such group referred to in the PSO are prisoners such as the man:

 "[Another] group of prisoners whose heightened risk of suicide is long-term are the small number of individuals who will often have carried out particularly disturbing crimes and rationally announce … that they have no intention of seeing out their sentence.

 "It is important to note that not all such individuals remain of the same determined state of mind. Some prisoners who … start their time in prison apparently determined to kill themselves do change their minds later and go on to serve their sentences safely. So it is essential not to jump to conclusions …

 "The ACCT CAREMAP should focus on increasing any incentives that might help the individual see something in life that makes it worth living – for example, contact with family, a role within the prison, education, work or religion. In addition, it is likely that a high frequency of supervision will be required.

 "At some point, however, it may become clear that the prisoner's determination is undiminished despite all possible staff efforts. Concerns may also be felt that maintaining the high level of supervision (possibly constant supervision) is inhumane. Such prisoners are often high profile & the Governor may feel under pressure to maintain the constant supervision indefinitely because of fear of media response if the prisoner killed him/herself. As these cases are rare, the establishment should

seek advice on an individual basis from the Area Safer Custody Adviser & from Safer Custody Group.”

KEY FINDINGS

13. The man was born in Manchester in February 1976. He was the middle of five children. He described having a difficult childhood. He reported that he began to run away from home at an early age and, at the age of 11, was taken into care by the local authority.

14. The man left school without qualifications. He subsequently gained a qualification in hotel and catering skills and then worked as a chef for around a year. After leaving that job, he moved abroad and apparently worked successfully in the Canary Islands as a time-share salesman. This career ended as a result of his increasing use of illicit drugs.

15. On 5 January 2007, the man was arrested and taken into police custody. He was charged with murder and was remanded into HMP Liverpool on 9 January.

16. In early July 2007, the man was convicted of murder and later that month was sentenced to life imprisonment for a minimum term of 27 years. By this time an ACCT plan had been opened as he was expressing suicidal thoughts. ACCT is the process through which prisoners are monitored and supported if assessed at risk of suicide or self-harm. Prison Service Order (PSO) 2700 provides advice and guidance on operation of the ACCT process. That includes advice in deciding on the appropriate frequency of conversations and observations with the prisoner. At times, it might be appropriate to place a person on constant supervision. This is where a designated member of staff keeps the prisoner within eyesight at all times. Constant supervision is a temporary measure that should continue for the briefest period possible. The ACCT process also includes devising a 'CAREMAP'. The CAREMAP should identify the factors that are causing distress to the prisoner and should identify actions that can be taken to help.

17. The man's ACCT plan remained open for the following six months and was still open when he was transferred to HMP Frankland on 11 January 2008. Frankland is a high security prison in County Durham and his transfer there was for reasons of standard sentence progression – moving from a local prison to a first stage lifer prison. A mental health worker at HMP Liverpool wrote a discharge report for Frankland in which she wrote:

    "I [first met the man] for an assessment on 15 August 2007 …

    "He presented with symptoms consistent with anxiety and panic attacks. He also described very low mood at times, tearfulness and poor sleep. He also stated that he had a lot of worrying thoughts, and always thinks the worst. When assessing his level of risk, he stated that he will not serve 26½ years, and would end his life at some point. He reported attempting suicide on various occasions including attempting hanging in

2002, and attempted overdoses in 2004 and 2006[2]. He also reports that both his sister and his auntie have committed suicide …"

18. The first Senior Officer (SO) told my investigator that he was the senior officer in charge of E wing when the man arrived in Frankland. He said E wing is a small unit used primarily for remand prisoners and for those who are difficult to manage in other parts of the prison. In his case, he refused to move to a standard unit or to the vulnerable prisoners unit. His reason was that he owed a considerable amount of money to drug dealers and was scared that he might be a target for assault by other prisoners. The first SO said that at that time the man was a quiet prisoner who largely kept himself to himself, hardly speaking to other prisoners. He then began to settle down and started a cleaning job. The first SO said the man was being monitored through the ACCT process at this time. His perceived level of risk was variable so his level of observations also varied. The first SO then moved to a different wing so it was many months before he had further substantial contact with him.

19. The second SO told my investigator that he attended a number of the man's ACCT case reviews in E wing after his initial arrival at Frankland. The man was then moved to C wing (C wing is one of four wings at Frankland that accommodates vulnerable prisoners). The second SO was based on C wing so he and the man then had more frequent contact. He said the man spoke quite a lot about his life including the fact that as a child he had spent time in care and that family members had committed suicide. In an attempt to encourage the man and show him that there was a way forward, the second SO spoke about how other people deal and cope with unfortunate situations that arise in their lives. This included talking to him about the fact there were people at Frankland serving longer sentences than him, as well as life sentenced prisoners who were younger than him. He also asked the man how people who knew him would feel if they were to receive a telephone call telling them that he had taken his life. The second SO told my investigator that although the man listened to these arguments, he would always counter them, saying, for instance, that no-one had cared about suicides in his family and that if he died, people would just get on with their own lives.

20. On 5 March 2008, a mental health nurse, saw the man for an initial appointment. He had been referred to the mental health team a fortnight previously. She noted that he was concerned about the length of his sentence. She noted that he: "… reports his sleep to be poor, appetite reduced and motivation low. He further reports to have intrusive thoughts of suicide …". She noted that he was being prescribed an anti-depressant, mirtazapine.

21. Following a referral from the mental health nurse, the man was reviewed on 16 April by a visiting consultant forensic psychiatrist from the contracted

[2] The man took another overdose while in HMP Liverpool, and he self-harmed on another occasion by cutting himself.

Mental Health Foundation Trust. The psychiatrist concluded that over the course of the past few weeks the man had developed a depressive illness in addition to a background of dysthymia (general low mood). The psychiatrist discussed his findings with one of Frankland's doctors and they agreed that the man should be prescribed a different anti-depressant, venlaxafine.

22. The following day the man was seen again by the mental health nurse who had seen him on 5 March. She noted that the man had agreed to start a course of supported self-help for depression based upon cognitive behavioural therapy (CBT) principles and set out in a book entitled "Mind over Mood". A fortnight later she made a further entry in his clinical records to say that he was continuing to engage with the "Mind over Mood" book.

23. The mental health nurse continued to see the man on a regular basis for the next few months and on 20 May, made the following note in his clinical records:

    " … Reports low mood over the past few days with increased suicidal ideation. Reports to continue to plan for suicide when he has ended the relationship with his girlfriend …"

24. Ten days later the mental health nurse wrote: "… reports mood, concentration and motivation to be low. Themes of hopelessness evident, suicidal ideation continues ..."

25. She saw him once again on 11 June when she noted:

    " … Symptoms of depression continue, sleep poor with early morning waking, mood labile (unstable) with diurnal (daily) variation, motivation impaired and negative cognition apparent. Suicidal ideation continues with mood improvements when he reports to have a plan for suicide …"

26. The man's ACCT plan (which was opened at Liverpool on 23 July 2007, and had remained open for nearly 12 months) was closed on 30 June 2008. Having remained closed for only one day, the ACCT plan was reopened on 2 July.

27. On 8 September, a Community Psychiatric Nurse (CPN) made the following entry in the man's clinical records:

    "He remains low. He says that he has lived with a general disinterest in life for many years and even before this sentence had regular suicidal thoughts … it is very difficult to motivate [him] at present. He reiterated his long standing feelings of suicide though said that he lacks the energy or will to act on these thoughts …"

28. The CPN told the investigator that he met the man soon after his arrival at Frankland. At that time he was on E wing and he seemed to be having difficulties coping. The CPN said the man often voiced thoughts of suicide but without acting on those threats. He was moved to C wing and then to D

wing, another of Frankland's vulnerable prisoners' unit, which appeared to help. The man also wanted to be prescribed anti-depressants as the previous prescription had not been renewed. The CPN discussed the request with one of the prison doctors who prescribed fluoxetine hydrochloride. The man settled down after this. His ACCT plan was closed in the middle of September and it remained closed for around seven weeks.

29. The first SO told my investigator that he was already based on D wing by the time the man arrived on that wing. The first SO said that the man admitted openly that he was misusing drugs. He was misusing both illegal drugs and prescribed medication that he was obtaining from other prisoners. In addition, his associates on D wing also had problems with drugs. (Prison Security reports from this time included a number of accounts of him attempting to both buy and sell medication. Other reports indicate that he was also acquiring hypodermic needles.) Frankland eventually acted to split up the group which included transferring him to C wing.

30. An ACCT plan was opened again on 6 November after the man took an overdose of his own medication in addition to some medication obtained from another prisoner. His clinical records show that he was suffering migraine headaches at this time and he told one of Frankland's doctors that he had taken the additional medication to help him sleep. The ACCT plan was closed on 24 November.

31. Another ACCT plan was opened for a brief period in the middle of December when the man said it was his intention eventually to commit suicide. He said that he "… didn't want to do it just now, but did wish to do it because he was only 12 months into a 30 year stretch".

32. On the evening of 7 February 2009, an officer saw the man lying in bed and tried to obtain a response from him. Gaining no response, the officer went into the cell and discovered a ligature around the man's neck which was tied to the bed frame. The officer cut the ligature and on examining him found that he had a pulse but was not breathing. Mouth to mouth rescue breaths were given followed by oxygen using a cylinder and airway tube. Ambulance paramedics attended, by which time the man was responding to verbal commands (he had apparently remained unconscious for 20 minutes). The man was advised that he should go to hospital but he refused to do so. He was moved to the healthcare unit. An ACCT plan was opened and he was placed on constant supervision. (The ACCT plan remained open for the remaining six months of his life.)

33. The man had an ACCT assessment interview the following morning in which he spoke about wanting to end the relationship with his partner due to the length of his sentence. At a case review following the assessment interview it was noted that "[he] explained that he wanted to end his life yesterday evening and appears indifferent that [he] was unsuccessful". Despite that comment, he was also noted as having no immediate thoughts of self-harm. He was taken off constant supervision and was instead to be

observed twice per hour with three recorded conversations each day. A new CAREMAP drawn up at this time identified that a goal for him would be for him to come to terms with problems he said he was having in his relationship with his partner.

34. During the following two months the man continued to receive support through the ACCT process. ACCT case reviews were held on a regular basis, usually around once per week. He continued to mention his partner at case reviews and she continued to visit him.

35. In the early hours of 23 April, one of Frankland's nurses made the following entry in the man's clinical records:

> "… Called to cell [at 1.40am]. Patient has multiple lacerations to right forearm as well as bruising around neck … Patient says that he has problems at home … and that he was genuinely trying to kill himself. He initially attempted the cutting and then subsequently applied the ligature in an attempt to strangulate himself …"

36. One of Frankland's Principal Officers (PO) told my investigator that he was the night orderly officer[3] on 23 April and he responded to an emergency call that the man had both cut himself and attempted to strangle himself with a ligature. Staff went into the cell, cut the ligature and managed to resuscitate him. Staff asked the man to move to healthcare for closer observation, however he refused to do so. The PO said that in all his time in the Prison Service he had never encountered a person who was as angry as the man about being saved. He said the reaction had convinced him that he was intent on taking his life and that there was every possibility that one of these attempts would be successful.

37. The man was moved into healthcare the following day and placed under constant supervision. A PO who worked in healthcare in a non-clinical capacity told my investigator that he met the man for the first time when he came into healthcare for close observation. The healthcare PO said they had many conversations about such things as the man's life before coming into prison and their shared interest in football. He felt that he got to know the man very well. The man spoke from an early stage about wanting to take his life. He told the healthcare PO that thoughts of suicide were always on his mind. Although the healthcare PO tried to tell the man that he did have things to live for, nothing altered his attitude towards taking his life.

38. Frankland's Mental Health Co-ordinator told my investigator that her role included managing the mental health team and co-ordinating mental health provision at the prison. She said she first met the man around April 2009 when she attended a number of his ACCT reviews. She felt that from around that time, he entered a period of crisis which was difficult to manage within a prison setting. She said that it was usual for him to make ligatures

[3] The Night Orderly Officer (NOO) is the person in operational charge of a prison at night time.

and he kept them in his cell "almost as a comfort blanket". (His records contain frequent references to ligatures being removed from his cell.) She added that a new and concerning phase started when he began to cut himself and to 'blood let'. That is, he would cut himself, allowing the blood to flow into the toilet or sometimes into a bowl. He would not allow staff to intervene which meant that they could not treat him until he collapsed[4]. He spoke openly about his intention to take his life. He also spoke openly about his background, including his time in care, and said that he was using medications that he was obtaining from other prisoners. The Mental Health Co-ordinator said staff put a great deal of effort into trying to help him and she did not think that any more could have been done in trying to stop him from taking his own life.

39. At an ACCT case review on 27 April, the man appeared more settled than had been the case for the past several days so his level of observations were reduced from constant supervision down to six observations per hour. Meanwhile, he was to remain in healthcare.

40. During an ACCT check the following night, an officer saw the man lying in bed and noticed an "involuntary movement of legs". The officer called the man's name and, when he failed to answer, the officer went into the cell. The officer found a ligature around his neck that had been tied to the bed frame. He was cyanosed[5], and had no pulse. The officer commenced cardio pulmonary resuscitation (CPR) and was joined by a healthcare worker who gave oxygen. The man began to respond and started breathing spontaneously. He was again placed under constant supervision.

41. The man was seen by one of Frankland's doctors on 29 April. The note of the discussion included:

> "…[the man] was alert, comfortable, good eye contact and rapport. Says wants to die as … sentenced for 30 years two years ago, recently his girlfriend outside seeing some other guy … [doesn't] want to live. On asking how I can help him, he said there is no way anyone can stop him, he denied any immediate self-harm intention but said next time he will plan and do it properly …"

42. In discussion with the investigator, the doctor said that the man made persistent comments about wanting to take his life and he was also persistent in self-harming. However, the doctor also said that the healthcare team were always hopeful that these thoughts might pass in time.

---

[4] In law, a patient who is deemed mentally competent may withhold consent to any medical treatment. If valid consent is not given, any treatment which involves touching, including the dressing of a wound, would amount to assault.

[5] Cyanosis is the term for the condition when the bodily extremities turn blue due to lack of oxygen.

43. The CPN told the investigator that at around this time the man began to talk to him about not wanting to spend 27 or more years in custody. His relationship with his partner was becoming strained and at an ACCT review he said that if his partner left him, he felt that he would have nothing to live for. The CPN told the investigator that as a psychiatric nurse, he would want to instil hope in people. He found that difficult with a man as he could not see a way out and who did not seem able to cope with the idea of staying in prison.

44. He had been taken off constant supervision on 30 April and instead was made subject to six observations per hour.

45. The man made two further attempts at self-strangulation on 3 May. The first attempt was in the early evening when he tore a strip from his bedsheet. Staff responded by removing the standard issue bed sheets which they replaced with anti-tear sheets. His second, and much more serious attempt, was a few hours later. It seems that he used a match to burn a hole through his anti-tear bed clothes and that allowed him to tear off a strip of material to make a ligature. He suffered respiratory arrest. Nurses treated him with CPR and oxygen and an ambulance was called. He was revived but was nevertheless sent to outside hospital. He was discharged back to Frankland a few hours later (in the early hours of 4 May). He returned to healthcare where he was placed under constant supervision.

46. After this, the man began to settle a little and on 22 May he was discharged from healthcare to C wing. By this time his level of observations had been reduced to four per hour, at irregular intervals.

47. On 25 May, the man made what appears to have been another attempt on his life, this time by cutting himself. An account of the incident was entered in his clinical records:

> "[The man is now in healthcare] on a constant watch following serious cut to arm resulting in [a large amount of] blood letting. Evidence suggests that one bucket was already flushed down toilet when he was found letting a second amount. He had sat behind his privacy board as if using the toilet and waved to the officer who was carrying out 4 times per hour observations whilst his other arm was bleeding out. Staff observed smear of blood on toilet and made further investigations to find he had lost large amount of blood …"

48. Following this incident the man was treated by healthcare staff before being transferred to outside hospital. Later that day the man discharged himself from hospital and was taken back to Frankland. Over the next few days he engaged in further episodes of 'blood letting' leading to another transfer to outside hospital where he received a transfusion of four units of blood. (I understand that his explanation to staff for his actions was that if he lost a sufficient amount of blood that would result in a rapid rise in his pulse and heart failure.)

49. To assist in determining possible provision of treatment to the man, the Mental Health Co-ordinator completed a "Record of Capacity Test and Best Interests Assessment" form on 28 May. This was to help determine whether the man had the capacity to refuse medical treatment. In response to a question as to whether he had an "impairment of, or disturbance in, the functioning of his mind or brain", she gave as her opinion that the man had no such impairment. In support of that opinion she wrote:

> "He has made a decision to die. He is declining interventions required i.e. ferrous sulphate (iron supplements) or blood transfusion. He is aware of his actions, the seriousness of them and the consequences of not accepting treatment. He is aware that at the point of collapse staff will intervene. He is able to satisfy his own needs i.e. phone calls and requests for medication. He is not displaying any impairment or disturbance of his functioning of mind. He is alert, orientated and able to retain information given."

50. An officer who was working in the healthcare unit during this period told the investigator that he spent time talking with the man. He had used his teeth to bite out the stitches in his arm causing it to start bleeding again and he said that he wanted to die. The officer asked the man about his family. He spoke about his daughter and the officer understood that she was around eight years of age, but he had never seen her. The officer told the man that he had daughters of his own and said that in a few years his (the man's) daughter would start asking questions about him and might want to visit. He officer also told the man that if he continued to bleed he would eventually collapse and once that happened, staff would go into the cell to treat him. He would not therefore die that way. the man staunched the bleeding at that point.

51. The man continued to harm himself through June by reopening his wounds and blood letting. He had several further admissions to outside hospital in the month, receiving more blood transfusions.

52. At an ACCT review on the morning of 16 June, an option discussed was the possibility of moving the man to the G4 unit (the 'progression unit'). His level of supervision was reduced to six observations per hour having been maintained on constant supervision for the previous 22 days.

53. The SO in charge of G4 told the investigator about the unit. He explained that the unit was established in response to national concerns about individual prisoners remaining in segregation units for lengthy periods of time. To try to correct inappropriate behaviour, G4 offers quick rewards for compliant behaviour with the aim of re-integrating prisoners back into the main prison. On arrival prisoners will be on the same basic regime as they would have been on while in segregation. This means that they will enjoy no earned privileges, have no television, no stereo, no access to their stored property and are required to wear prison issue clothing rather than their own. They will also have less time out of cell for association. After this, prisoners earn privileges each week provided their behaviour is

acceptable. Poor behaviour can result in the loss of a privilege, but the following week is treated as a "fresh start" so prisoners can quickly put any dip in standards behind them. The intention is for prisoners to successfully achieve re-integration into the main prison within around 12 weeks. The G4 SO said that 80 prisoners had been on the programme to date, of whom 60 had been successful. He added that the unit has a high staff to prisoner ratio. It can take up to 16 prisoners and during the day is staffed by four officers, including the senior officer.

54. The G4 SO acknowledged that the man was not a typical prisoner for the unit. However, there were good reasons to offer him the opportunity to join the unit as he had struggled to adapt to life on the main residential units. The intention was for the regime on G4 to help break his cycle of self-harming behaviour. In addition, he was hoping to move to a prison closer to his home area, such as HMP Wakefield, but it would be difficult to persuade another prison to take him while he remained a difficult prisoner to manage.

55. The option of a move to the G4 unit was discussed again at another ACCT review on 22 June when it was noted that he "… would like to have another chance at G4 and move forward. He has said that he would be willing to do a structured programme and transfer to a prison closer to home." (For some months, one of the aims of his CAREMAP had been to: "Move to G4 landing and … exit strategy to HMP Wakefield.") His level of observations were maintained at six per hour.

56. One of the panel members at the ACCT case review on 22 June was the Residential Governor. He told the investigator that he was the line manager of the healthcare PO. He said that in the past, it was the Duty Governor who attended ACCT case reviews for prisoners in healthcare. However, that meant a lack of continuity in the case of a prisoner on an open ACCT plan for a period of time. New arrangements were therefore introduced where the Safer Custody Governor attended the reviews. The Residential Governor explained that in the Safer Custody Governor's absence, he attended some of the man's early ACCT reviews in healthcare and it then seemed appropriate for him to continue to attend for purposes of continuity. (The man's records confirm that the Residential Governor attended many of the man's ACCT case reviews.) The Residential Governor gave similar evidence to other witnesses about the man's apparent determination to take his life.

57. The man's optimistic thoughts about a move to G4 were short lived. He quickly changed his mind about transferring there and, on 7 July, started another episode of blood letting. He initially refused clinical treatment and was placed under constant supervision in a 'camera-cell'[6] in healthcare. He had used a razor blade to cut himself and he refused at first to surrender the blade. An officer eventually persuaded him to hand over the blade.

---

[6] Some of Frankland's healthcare cells are fitted with cameras to more easily allow for close observation of prisoners at high risk of self-harm or suicide. The man spent time in such a cell on more than one occasion.

58. The man remained on constant supervision for two weeks until a case review on 21 July, when it appeared that his mood had lifted.

59. Having spent most of the previous two months in healthcare, the man was moved on 27 July to D wing. His level of observations at this time was four per hour. He once again cut himself that night, although he told staff that this had been an episode of self-harm rather than a suicide attempt.

60. On the morning of 5 August, the man took an overdose of prescribed medication causing him to vomit and also causing great sedation. He was moved back into healthcare and placed under constant supervision once more. He remained unwell for most of that day. He claimed to have taken ten tablets of carbamazapine (medicine for treating epilepsy) and 20 tablets of Amitriptyline (antidepressant medication). He had obtained this medication from other prisoners and told the healthcare PO that he had assumed that if he took sufficient of the medication he would fall asleep and not wake again.

61. The man spent several days on constant supervision. In the early afternoon of 9 August he was given a disposable razor so he could shave[7]. The following two entries, the first at 2.25pm and the second at 3.15pm, were made in his ACCT document:

> "[The man] bit off razor blade whilst having a supervised shave and was restrained for his own safety and that of the staff. Attempts made to retrieve the blade but he claimed he has swallowed it …"

> "Despite assurances by [the man] that he would return the razor he has not, he claims he has swallowed it. On checking his cell again a hypodermic needle was removed. While chatting with him he claims he has still got the blade …"

62. Another SO told the investigator that he spent three or four hours of the night of 9 into 10 August carrying out constant supervision on the man. He said he had done this on two or three previous occasions but on this particular night the man had spoken more than before. The first comment he made that evening was to say that he "fancied a trip to hospital". He said he had a razor blade and he intended to use it. The SO asked the man to hand over the razor but he handed over two hypodermic needles instead. He then began to speak about his family, including his sister who had committed suicide. He said that he had been close to his sister and he felt partly responsible for what she had done. He spoke about his personal history including his time working abroad and the crime he committed that resulted in his long sentence. He said he had messed up his life. Eventually, he handed over the razor blade telling the SO that he had always been alright so he would not give him extra problems that night. The

[7] Most prisoners are allowed to retain a razor in their own possession. If a prisoner is deemed at risk of self-harm he might only be allowed a razor while shaving under supervision. He will hand back the razor once he has shaved.

SO said that the man settled down after this and the remainder of the night was restful. Despite that, the SO said he was more convinced that night than previously that the man would take his life one day.

63. At an ACCT case review on 10 August, the man was noted to be "looking and sounding a lot better than [at] his previous ACCT review". He asked to move to a standard wing saying that healthcare was not the place for him as he had no interaction with the other prisoners there. He was told that he would remain in healthcare for the time being but the prison would look at the option of finding him a job "as a small step forward". In the meantime, he was to remain on constant supervision.

64. The healthcare PO chaired an ACCT case review on 14 August when the man was taken off constant supervision. The Residential Governor was also at the review as were a healthcare representative and a chaplain. The healthcare PO's summary of the review included:

> "He attended his review in a good, confident, mood … No thoughts of self-harm or suicide at this moment in time. He is looking forward to [going] to G4 and [we] have agreed to move [him] there on Monday … We have reduced his observations to 5 [times] per hour."

65. Later that day, the man had a consultation with the Visiting Consultant Forensic Psychiatrist from the contracted Mental Health Foundation Trust. The psychiatrist noted that he:

> "… told me that his attempts at suicide were "on the spur of the moment" and were more likely to happen when he was bored or when he had too much time on his hands …"

66. However, the psychiatrist went on to note that:

> "He told me that he has made a rational decision to end his life and he did not think that any treatment for any sort of mental disorder will change his view …
>
> "On mental state examination, he was normal in mood and affect. He was calm and relaxed during interview, he expressed himself very well and I saw no evidence of mental illness. I certainly saw no evidence of a depressive illness."

67. The psychiatrist told the investigator that this was the only time he met the man and that the consultation would have lasted around 20 to 30 minutes. He said the man showed himself to be articulate, relatively intelligent and with good social skills. When he spoke about his decision to take his life, he was very calm in arguing that he had reached what he considered to be a rational decision. There was nothing in his manner to cause the psychiatrist to doubt his sincerity although he did not gain the impression that the man was planning to harm himself in the very short term.

68. On the evening of 16 August, the man told a nurse he was unhappy about the move to G4 wing and that the next time he attempted suicide would be the time he would succeed. However, at an ACCT case review the following morning, he said that his comment the previous night had been taken out of context. He said he was going to give G4 “a try”. His level of observations was adjusted down to four times per hour. The first SO was on the review panel that day. He told the investigator that the last time he had seen the man was when he had taken the serious overdose 11 days earlier. The first SO noticed a marked improvement in the man since that occasion. On this occasion he was clean, smartly presented and enthusiastic about moving to G4. He said he wanted to make a fresh start and go through the G4 programme. The first SO understood that his motivation was his hope to be able to move to a new establishment closer to his home area. Following the case review he made the move to G4.

69. An officer who had had previous dealings previously with the man in healthcare made an entry in the man’s records shortly after his arrival on G4:

> “Not a great start to his stay in G4. Was given a razor and on returning it to staff I noticed … the blade had been removed. [The man] was strip searched, nothing found. He claims he removed the blade to cut his toenails and then dropped it down the drain.”

70. Later on, the same officer carried out the man’s induction into the unit. He told the man about the education classes and that it would be of benefit for him to come out of his cell to go to classes. He would be paid for going to education and it would give him the opportunity to mix with others. The officer reminded the man that G4 had a high ratio of staff to prisoners so there would always be staff available to speak with him if that was what he wanted. The officer told the investigator that the other prisoners on the unit had also gone to speak with the man.

71. One of the G4 officers told my investigator that when the man came to G4, he was asked to settle him into the unit by encouraging him to come out of his cell as much as possible. He did this by giving the man cleaning jobs. Even after he had finished a job staff allowed him to stay out of his cell to socialise with the unit cleaner. The officer said the man seemed to be in good spirits. However he thought from what he had heard about his self-harming history, that he was likely to succeed in his suicide attempts at some point. This included the possibility that he might die accidentally following an act of self-harm or perhaps his body might just “give up”.

72. At just before lunch-time on 20 August he had another ACCT review. The review was chaired by the G4 SO. Two members of staff who knew him very well, the healthcare PO and the CPN, also attended the review. The G4 SO noted that both the healthcare PO and CPN remarked on how much better the man was looking. The review panel agreed that the observations could be reduced from four to two per hour. The G4 SO told the investigator that the man had not harmed himself for some weeks and,

based on that and on how he presented that day, he would make the same decision again about the reduction in observations.

73. The investigator asked the G4 SO whether, with the benefit of hindsight, he now thought the man might have deliberately engineered the reduction in observations to allow him the opportunity to make another attempt on his life. The G4 SO did not think that this was the case. He said the man realised that even with the reduction in observations, he would still not know when the next check would be made. He would also have known that provided he continued to behave as though his level of risk had diminished, the next step would be to reduce his monitoring to just several interactions per day. At that point, he would have found it easy to attempt his life without being found in time.

74. The healthcare PO told the investigator that he telephoned G4 each day after the man's transfer to find out how he was getting on. His reason for doing so was in anticipation, given all that had happened before, that he could return to healthcare at any time. Thursday 20 August was the man's fourth day on G4. When the healthcare PO attended the ACCT review, he found that the man was doing well. He was doing some cleaning work and keeping his cell clean and tidy. Based on this good progress, he was to be offered two privilege choices, rather than just one, at the end of his first week on G4. He said at the review that he was feeling good and looking forward to a visit from his partner at the weekend. The panel decided that his observations could be reduced to two per hour. The healthcare PO said that the reduction was appropriate based on the improvement in the man's demeanour over the course of the previous 15 days.

75. The CPN told the investigator that the ACCT review on 20 August was very positive. The man mentioned that a privilege allowed the following day was to wear his own clothes. He was also looking forward to receiving some canteen[8] items and he asked about a claim form for some trainers that had gone missing. The CPN said the man seemed to be adjusting to G4 and he did not think it inevitable that the man would one day take his life. The CPN said that, in his view, the difficult time the man had had in his final months was due to his relationship with his partner. The CPN hoped the man would find other resources to help him deal with his sentence in the longer term. The CPN told the investigator that, on reflection, he felt it likely that at the last ACCT review the man had tried deliberately to convince the panel that his level of risk had diminished.

76. A G4 officer also on the review panel that day told the investigator that the man was quite fidgety during the review and did not make good eye contact. At the same time, however, he talked very positively about how he was getting on in the unit and his future options in moving to a prison closer to Manchester.

---

[8] The canteen is the prison shop. Prisoners can deposit money into a prison held account and can use those monies to purchase items from the canteen such as cigarettes and sweets as well as PIN phone credit. They submit their orders by completing canteen sheets.

77. The investigator spoke to Frankland's Head of Safer Custody for his view on the difficulty of keeping safe a prisoner who is determined to take his life. The Head of Safer Custody said that the only way to achieve such an end would be to keep the person on constant supervision and preferably in a safer cell (a cell designed to limit opportunities for self harm). He added, however, that to keep a person on this level of observations for an indefinite period of time is at odds, in general, with the advice contained in the Prison Service Order (PSO 2700) dealing with suicide prevention and self-harm management.

78. Another of Frankland's SOs told the investigator that she met the man for the first time on 20 August. She spent a lot of time that day helping him with a problem with his cash account. She had been told that the man would not be receiving a canteen order as he had no money in his account but he explained that the problem was that his canteen sheet, which had credit on it, had not been forwarded when he moved from healthcare to G4. The SO said it took her around an hour and a half to resolve the problem but she was eventually able to confirm that the man did have funds and would receive a canteen sheet the following morning. She said the man understood how prisons worked and so was not annoyed at all about the mix up.

79. The SO did not see any signs of the man being at risk that day. He was quite cheerful and upbeat. He spent time on the telephone speaking with his partner and was looking forward to her visit. He had also spent time that afternoon helping the wing cleaner and was going to help out again the following day.

80. Another of Frankland's officers told the investigator that he had had some contact with the man before his arrival on G4: he had observed him at times when he was on constant supervision and supervised visits from his partner. On the afternoon of 20 August, the officer came to G4 to cover staff shortages there, arriving just before the evening meal was served. The officer said the man was unlocked to collect his meal and then locked back into his cell. During the next hour or two he came out again to have a shower and to use the telephone. (His records show he also had a haircut that evening.)

81. The officer said the man was using the telephone when the nurse arrived on G wing at 7.00pm with the evening medication. The man ended his call to collect his medication and then asked the officer if he could use the telephone again. The officer told him that another prisoner was waiting to use the telephone and, as lock-up time was due at 7.15pm, he would have to complete his call the following day. The officer told the investigator that the man's mood seemed improved compared to the last time he had seen him, which was when he was in healthcare. (The investigator asked Frankland for a transcript of his final telephone conversation, which had been to his partner. Unfortunately, a problem with the computer system meant that the call could not be retrieved.)

82. My investigator spoke with the nurse who distributed the evening medication on G wing that evening to ask why the man's prescription chart contained no initials to confirm that the man had received certain of his medications that evening. Did this mean that the man did not receive it? The nurse said she recalled giving the medication as she made a point of telling the man that this was his last prescribed dose of evening zopiclone, and if he wanted another prescription, he should speak to a nurse in the morning. She could not recall omitting to sign the prescription chart. She explained that charts for prisoners receiving night time medication were kept together, although sometimes a chart might be missing if it can be with the doctor for a new prescription.

83. On duty on G wing for the night of 20/21 August were an officer and an Operational Support Grade[9] (OSG) member of staff. The officer came on duty at around 7.30pm on 20 August and checked the man a few minutes later. Thereafter, the man was checked twice per hour as required by the ACCT plan.

84. At just after 1.00am on 21 August, the officer looked into the man's cell and saw him sitting on the floor by the window with a ligature around his neck. The ligature was tied to the window latch. The officer radioed the control room to notify them that there was a Code Black[10] incident. It was clear to the officer that it was an emergency situation and so he decided to enter the cell straight away without waiting for back-up.

85. However, when the officer attempted to open his sealed key pouch[11], he could not break the seal. He then ran to the centre office, which was about 25 metres away, and asked the OSG to cut the seal with scissors. The officer went back to the cell, opened the door, cut the ligature and on checking the man found that he had no pulse. At this point an SO and another officer arrived. The staff started cardio pulmonary resuscitation (CPR). A nurse arrived a few minutes later. She checked the man for a pulse and also made further checks. Once she had completed those checks, attempts at CPR resumed.

86. The nurse called for the defibrillator[12], which on of the officers collected from the centre office. The defibrillator pads were attached to the man's chest, but it advised that no shock should be given and that efforts at CPR should continue. After five minutes of CPR, the defibrillator was used again. Again it advised no shock, but CPR to continue instead. Staff continued with CPR

[9] Operational Support Grade staff do not receive the same level of training as prison officers staff and have limited direct contact with prisoners.

[10] Code Black indicates a prisoner with potential life threatening breathing difficulties.

[11] At night time, officers carry keys in a sealed pouch which must only be opened in the case of an emergency.

[12] A defibrillator measures electrical activity in the heart and emits audible instructions on management of the patient such as whether or not an electrical shock should be given to stimulate the heart.

until the arrival of ambulance paramedics at about 1.25am. After treating the man at the scene, the paramedics took him to outside hospital where efforts at resuscitation continued. Their efforts proved unsuccessful and the man was pronounced dead at 2.20am. He had left behind a 'goodbye note' to his partner saying that he was sorry but he could not "take the pain anymore".

After the man's death

87. The man's partner lives in Liverpool. Due to the distance to her home from Frankland, the prison contacted HMP Liverpool to ask members of their staff to visit to break the news. When staff from Liverpool visited, they found the house boarded up.

88. Frankland's Family Liaison Officer (FLO) then discovered that another prisoner's mother had sent a text message to the man's partner informing her of the news. Advice to prison FLOs about breaking the news of a death in custody advises strongly against doing so by telephone. The FLO was aware of this guidance, however given that the man's partner had already been contacted by an unofficial source, she decided that the best option was to make immediate contact herself to confirm the news officially. This, therefore, meant making contact by telephone. The FLO did this at 1.45pm. The man's partner asked to visit the prison and to see the cell where her partner died. Arrangements were made for the visit to take place the following Monday. The man's partner was told that Frankland would provide support with funeral expenses.

89. The man's property was returned to his partner. She queried possible missing items but was told that following searches, no other property could be found. Frankland further explained that it was common practice for prisoners to exchange items of property with other prisoners in return for other items, including perishable goods.

90. Frankland held a hot debrief on the day after the man's death. The prison care team were made available to the staff involved in his care. Staff told my investigator that they felt well supported. Checks were made on other prisoners on open ACCT plans.

ADDITIONAL INFORMATION FROM PRISONERS

91. The investigator spoke to a number of prisoners at Frankland. The first, said that he first met the man some time in July 2008 when they were both on F wing. He said they had a good relationship and spoke about many different things. The man was never depressed, although he repeatedly said that he would kill himself one day. He said this in a "matter-of-fact" way. He accepted the fact that his partner was beginning to make a new life for herself. The prisoner said the man enjoyed smoking and enjoyed taking drugs. The prisoner did not believe that the man had any problems funding his drug habit and did not believe that he had very much drug debt. The prisoner thought the man was trying to "play the system" when he told staff that people were threatening him because he owed them money.

92. The prisoner was certain that the man would find G4 unit difficult given that he would have no television and would have to behave and comply with the regime. The man's cell on G4 was below his own cell and they would talk out of the window at night. On the evening before his death the prisoner was tired and went to bed early. When the man shouted out for a chat, he called back to say he was already in bed and would see him the next day. He added that he was certain the man would take his life one day.

93. A second prisoner told the investigator that he first met the man in November 2008 on D wing. The man's mental health then began to deteriorate and he attempted suicide but was resuscitated by staff. The second prisoner said that after the man's transfer from D wing they would still meet each Thursday at Roman Catholic mass. Although the man promised that he would not make another attempt on his life, he then began to blood-let. The second prisoner said that the man found it difficult to come to terms with the fact that his partner was making a new life for herself. The second prisoner thought that the man should have been transferred to a psychiatric unit. However, he also believed that the man was determined to die and would have taken his life eventually wherever he was located.

94. A third prisoner told the investigator that he knew the man from C wing. During this time he made two serious attempts on his life and was then moved to healthcare. The third prisoner thought that the man was clinically depressed, which he thought "anyone could see." He did not think that the staff wanted to help the man.

95. A fourth prisoner told the investigator that he was located on G4 when the man came to the unit in August 2009. They had met previously, although that was only to the extent of exchanging greetings when they saw each other. However, when the man came to G4, the fourth prisoner tried to help him settle by checking that he had tobacco and ensuring he came out of his cell for association and to use the wing telephone. He said the man was "fed-up" with not having a television but apart from that he seemed to settle quite well into the unit. He did not speak about suicide but did speak about the length of his sentence saying that if he ever got out of prison, he would by then be an "old man". They chatted on the evening of 20 August when

the man gave no signs that he was about to harm himself again. The fourth prisoner added that staff “pulled out all the stops” for the man by allowing him more use of the telephone and more time out of his cell than he was entitled to.

ISSUES

The man's intention to take his life

96. The man spent a little over two years in prison custody and for the vast majority of that time was subject to support and monitoring through the ACCT process. He had been sentenced to life imprisonment for a minimum term of 27 years. Soon after sentencing he began to declare that he would not serve that amount of time and would take his life instead. Despite making such a stark statement, the evidence from the staff and prisoners clearly indicates that he was able to engage with prison life. He made friends with other prisoners and seems to have had no difficulty in his interactions with staff. As a result, the man appears to have had an ambivalent attitude towards suicide, stating more than once that his intention was to take his life one day, but not on any particular day.

97. The main support in the man's life at this time was his partner. She continued to visit him at Frankland despite the distance from her home in Liverpool. However, the evidence indicates that their relationship was becoming strained and the man said at an ACCT review that if his partner left him, he would have nothing to live for.

98. PSO 2700 provides advice and guidance on operation of the ACCT process. The advice includes setting an apparently appropriate frequency of conversations and observations with the prisoner. No explicit advice is given about situations where any particular level of observations should be chosen rather than another level. The advice does recognise that there will be occasions when it might be appropriate to place a person on constant supervision (where a designated member of staff keeps the prisoner within eyesight at all times).

99. The man was monitored through the ACCT process for a great deal of his time at Frankland (as, indeed, he was at Liverpool). That included periods when he was maintained on constant supervision. However, in keeping with the guidance within PSO 2700, he was never maintained on constant supervision for excessive periods of time. In general, I consider that the adjustments in the man's levels of observations were consistent with what one could reasonably expect. I was also pleased to note that most of the ACCT reviews were attended by clinicians and governor grade staff, and that there was a consistency in attendance of several key members of staff.

100. The investigator asked Frankland's Head of Diversity, Decency and Safer Custody to comment on the man's management as a prisoner at high risk of suicide. He wrote in response to say:

> "When [the man] started seriously self-harming in February 2009, we commenced ACCT monitoring and, when he presented as unable to cope on a wing, we moved him to our Health Care Centre, and latterly to our G4 Progression Unit when we believed his suicidal determination had diminished.

"[He] had a long term Care Plan and the Health Care Discipline Manager, Head of Residence and the Mental Health Team Manager and myself regularly attended his ACCT Case Reviews. Staff dealing with [him] were also fully briefed about his issues and the contents of his Care Plan.

"We also facilitated frequent phonecalls by [him] to his girlfriend even when he had no money to pay for these and also regular visits.

"Because we believed we were latterly making progress with [him] (despite many setbacks), we made no specific approaches to [Safer Custody Group] or [the safer custody advisers for the High Security estate] for individual advice about how to manage him, although HMP Frankland's issues with prolific self-harmers were consistently raised at quarterly High Security Safer Custody meetings and also when [the safer custody advisers for the High Security Estate] visited the prison. Because HMP Frankland has an 80-bed Dangerous Severe Personality Disorder Unit on which several prolific self-harmers are resident, prolific self-harm/suicidal determination has been an issue which we have had to address over several years."

101. The Governor has explained why no specific approaches were made to the safer custody advisers for the High Security estate or Safer Custody and Offender Policy Group. While I am not certain that there would have been any changes in the man's management had individual advice been sought, I nevertheless suggest that Frankland should have discussed the specifics of his care as indicated by the PSO.

The Governor should remind staff to follow the guidance contained in PSO 2700 about seeking advice from area advisers or Safer Custody and Offender Policy Group when a prisoner is at a long term high risk of suicide.

Whether the man should have been placed on G4 unit

102. The G4 unit, correctly the 'Progression Unit', was established to deal with prisoners whose behaviour has the potential to result in them spending extended periods in the segregation unit. The prisoner starts in G4 on basic regime with no privileges. However, co-operative compliant behaviour is quickly rewarded by the granting of privileges. This continues week by week and the aim, after 12 weeks, is to reintegrate the prisoner to a standard prison wing.

103. The man was not therefore a typical candidate for placement on the G4 unit. The pattern of behaviour that Frankland wished to correct in his case was not a constant flouting of Prison Service rules, but instead an almost constant cycle of self-harm. Had that pattern ceased, it is likely that he would have been able to obtain a transfer to a prison much closer to his home area, such as Wakefield.

104. In order to make life on G4 a little easier for him, the man was allowed out of his cell to assist the wing cleaner. He was also allowed to remain out of his cell socialising with the cleaner after they had finished their work. Even so, he would still have spent a lot of time alone in his cell with no television for distraction (he had a television in healthcare). Undoubtedly he would have found the early weeks difficult until he began to earn privileges.

105. Although it could be argued that G4 was not an appropriate environment for the man, it was entirely reasonable for Frankland to try something different. He had fallen into a pattern of self-harming behaviour that brought him close to death on a number of occasions and also resulted in him being sent to outside hospital for treatment. And on two occasions "goodbye" letters were found in his cell. As well as his own distress and the impact on his well-being, his actions were having a significant operational impact on the prison in addition to a considerable emotional impact on staff. He understood how G4 operated and he agreed to the move. The man's hope, he had said, was to move to Wakefield or Manchester and he knew that his chances of obtaining a transfer would be greatly improved through successful completion of the G4 programme. I do not therefore criticise Frankland for trying this option.

Reduction in the level of observations during the final days

106. The final ACCT plan was opened on 7 February and it was still open over six months later when the man took his life. His level of observations was adjusted numerous times in the intervening period and on several occasions he was maintained on constant supervision. His final spell on constant supervision commenced on 5 August in response to an overdose of prescribed medication. His explanation was that he had hoped to fall asleep and not wake again. He remained on constant supervision for nine days. At an ACCT review on 14 August the man was noted to be in a confident mood and looking forward to his imminent move to G4. His level of observations was reduced to five per hour. At the next ACCT review three days later observations were further reduced to four per hour. The final ACCT review was on 20 August, the day before the man's death, when observations went down to two per hour.

107. The steady reduction in the level of observations in the final days was in response to a perceived improvement in the man's spirits. He claimed to be optimistic about his move to the G4 unit with the longer term hope that he might obtain a transfer to prison close to his home area, such as Wakefield or Manchester.

108. Deciding on an apparent appropriate level of observations for any given prisoner on any given day is a matter for the ACCT review panel sitting at that particular time. Prison Service Order (PSO) 2700 deals with suicide and self-harm prevention and with the ACCT process. The PSO gives no examples of situations where a particular level of observations might be

applicable. Staff are expected to deal with prisoners and situations as individuals.

109. The man had remained on an ACCT plan for a long time and his self-harm was significant over that period. It is possible to argue that the reduction in the level of observations on him from constant supervision down to two per hour was rather quick. That said, there is no explicit guidance about the circumstances when any particular level of observations might be appropriate. Instead, review panel members depend on their own personal judgement when making these decisions.

110. Panel members will, of course, have received training in the ACCT process which will include the various levels of observations that are available. Aside from this, they are guided by their own experience, that of the other panel members, and by their own personal knowledge of the prisoner. On the last of these, I recognise that two of the three panel members knew him extremely well. They were the healthcare PO and the CPN. They would have been among the best placed of all the staff at Frankland to judge his level of risk on 20 August. I am therefore confident that the panel members made an appropriate judgement, based on their knowledge and experience and in the circumstances at that time.

The man's ability to acquire prohibited items

111. I was surprised at the apparent ease with which the man seemed able to acquire prohibited items. He acquired razor blades which he then used to cut himself. And on one documented occasion he surrendered needles when asked to hand over a razor blade that was in his possession. He also took a notable overdose of medication that he appears to have acquired from other prisoners. I understand that the man was subject to a standard level of random cell searches. This meant that his cell would be searched around once per month. The Governor will wish to assure himself that appropriate processes are in place to lessen opportunities for prisoners to acquire potentially dangerous items and that staff are vigilant when using these processes.

The sealed key pouch

112. For security reasons, officers on duty at night time carry cell keys within a tamper proof sealed pouch. The seal must only be broken in the case of an emergency and officers must give an account for the reason if they ever break the seal. When the night officer discovered the man with a ligature around his neck, he realised he needed to go into the cell. Unfortunately, he was unable to break the seal of his key pouch so had to go to the centre office where the OSG cut the seal with scissors. The officer told my investigator that he was unsure why he had not been able to break the seal by hand as he has been able to do this in the past. The Governor will wish to satisfy himself that the key pouch seals used at his prison are fit for purpose (that they will not break accidentally but can be easily broken by hand when needed).

Clinical care

113. The clinical review has found that the man received equity of care which included being offered admission to healthcare and to outside hospital where appropriate. He was referred to the mental health team from whom he received appropriate interventions and he was also referred to an outside specialist mental health unit. The clinical reviewer concluded that all reasonable measures seem to have been taken by staff to reduce his risk of suicide.

114. The reviewer has made some criticism about aspects of the clinical record keeping. In particular, she has referred to omissions in the completion of prescription charts and a failure to time entries made in the electronic clinical record (EMIS). The clinical reviewer has made recommendations about these omissions which are contained in the clinical review and which I repeat below:

    All patient details should be properly completed on the [prescription and administration charts]. When dispensing medications, the month of administration should be clearly stated. When changes are made to these charts all changes must be signed by the person designated to do so, i.e. the doctor or pharmacist, so that mistakes are minimised and possible misinterpretations eliminated.

    Times should be given on all [EMIS] records. [Nursing and Midwifery Council guidance] states "In line with local policy, you should put the date and time on all records. This should be in real time and chronological order and be as close to the actual time as possible".

CONCLUSION

115. The man's death was unusual when compared to many of the other deaths investigated by this office. Some prisoners take their lives without having given out any sign that they are about to do so. Others take their lives during a period of crisis that has been recognised by the prison and some have done so at a time when they are being actively supported through the ACCT process. What makes the man unusual was his apparent long term determination to take his life, combined with his readiness to tell staff about his intentions. He made several serious attempts to take his life before August 2009 and was twice resuscitated by staff. On two previous occasions he had written "goodbye" letters to his partner that were discovered in his cell. Throughout his sentence staff took him seriously and made commendable efforts to address his problems and to keep him safe. I consider it a great credit to staff commitment that he remained alive for so long considering his determination to draw it to a close.

116. A key component of the ACCT process is the identification of a coping resource or mainstay that might prevent the person taking their life. With the man, he seemed only able to focus on his partner. She continued to visit him despite the distance from her home to Frankland and despite the length of his sentence. However, it is also clear that while the man looked forward to her visits, he also found it difficult to cope once they came to an end.

117. The NOMS policy is limited because it is designed to offer help and support to people during a period of crisis or when they ask for assistance. However, no suicide and self harm prevention policy could ultimately stop a very determined person from taking their own life.

118. Staff at Frankland worked very hard in attempting to support the man during what was clearly a difficult period in his life. I believe that they did everything that could have been reasonably expected of them in managing his persistent acts of self-harm and attempts to take his life.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Prison Service's response to the recommendations appears in italics below each recommendation:

1. The Governor should remind staff to follow the guidance contained in PSO 2700 about seeking advice from area advisers or Safer Custody and Offender Policy Group when a prisoner is at a long term high risk of suicide.

    Prison Service response: Recommendation accepted. Governor's Notice to Staff to be issued. Target date for completion is 30 October 2010.

The Prison Service further added that:

> *(It should be noted that by the time the man was moved to G4, he had been stabilised following a sustained multi-disciplinary input. No further advice was required on his management. Minuted High Security Estate safer custody meetings take place on a quarterly basis where cases of sustained/serious self harm are discussed.)*

The following two recommendations are made by the clinical reviewer and are for the head of healthcare.

2. All patient details should be properly completed on the [prescription and administration charts]. When dispensing medications, the month of administration should be clearly stated. When changes are made to these charts all changes must be signed by the person designated to do so, i.e. the doctor or pharmacist, so that mistakes are minimised and possible misinterpretations eliminated.

    Prison Service response: Recommendation accepted. A new Standard Operating Procedure will be compiled with all recommendations and approved via the Drug and Therapeutic Committee. Target date for completion is January 2011.

3. Times should be given on all [EMIS] records. [Nursing and Midwifery Council guidance] states "In line with local policy, you should put the date and time on all records. This should be in real time and chronological order and be as close to the actual time as possible".

    Prison Service response: Recommendation accepted. Healthcare at HMP Frankland has now moved to SystmOne and times are recorded automatically.